Empowerment, Ethics and Intercultural Competence in Short-Term Medical Missions in the Dominican Republic

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Notes on Translation and Informant Identity

All of the interviews in the Dominican Republic, with the exception of the interview with the U.S. missionaries, were conducted in Spanish. Therefore, all quotes and paraphrases are based on my translation; I collaborated with my two assistants in cases where slang or vocabulary was unfamiliar to me. All translation, and indeed all relaying of another’s words, is inherently fraught and complex with the potential of losing original meaning or misrepresenting a person’s words. In my translations, I have prioritized the portrayal of the general meaning of my informant’s words over literal translation into English, especially where Dominican slang is involved.

In order to protect the confidentiality of informants who did not wish to be identified, I have chosen to use “Barrio Madrid” as pseudonym for the neighborhood in the city of San Pedro de Macoris in which I conducted my research. Where first names only are cited, these are pseudonyms and original names have been changed to protect informants who wished to remain anonymous. As a way of acknowledging their contribution to my work, I give credit to quotations from key informants—including doctors, pastors, missionaries, and GSOP faculty and students—who agreed to allow me to use their name in my thesis.

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Introduction

In his 1966 study *The Churches of the Dominican Republic in the Light of History*, William Wipfler argues for a historical approach to solving societal and, in his case, religious issues in the Dominican Republic, saying, “the difficulties of today are not solely the result of the rapidly changing social conditions, as so many persons tend to believe, but rather are inherited from the past and perpetuated as part of an accepted system and structure, or are the by-product of that system” (10). One of the major issues that involves established systems and structures facing our world today is the quality and access of healthcare in developing countries. This thesis will explore one way in which healthcare workers are seeking to provide healthcare in the Dominican Republic—short-term medical missions (STMMs). This thesis situates STMMs in a religious and cultural context while interrogating the ethics of the engagement and suggesting routes for STMMs to become more empowering and interculturally competent.

Religion in the Dominican Republic

Brendan Thornton in *The Cultural Politics of Evangelical Christianity in the Dominican Republic* locates Evangelicalism and specifically Pentecostalism within a religious marketplace of sorts that includes a variety of spiritual beliefs that serve practical cultural and societal purposes. Underlying all of the Dominican spiritual beliefs is a strong belief in the miraculous and the spirit world (Thornton 90). Thornton says, “People put the spirit world to work for themselves and are often creatively interpreting, reinterpreting, and creating as they go” (100). While he argues that, “popular or ‘traditional’ religion in the Dominican Republic is always already Christian,” (103) Thornton also discusses the prevalence of *brujeria* or witchcraft, syncretism between Catholic saints and African or
Haitian luá and the Pentecostal incorporation of “local music, fests and a consultation structure” that is local and familiar (95; 102). Conflicts between Catholics and Protestants are fairly common in the Dominican Republic as the growing Protestant presence often condemns the Catholic focus on the saints as idolatry or even demon worship (Thornton 106).

Complicating discussions of religion in the Dominican Republic is a dissonance between official and practiced religion. Thornton notes that, “Voudou, for example, has always been opposed to Catholicism by outsiders despite the fact that voudou practitioners consider themselves to be Catholic” (102). This dissonance between discourse and practice is also seen in the interactions between health and religion in the community where I conducted my research, Barrio Madrid. Within the Christian faith even Evangelicals who condemn Catholics as “demon worshipers” will seek care at Catholic hospitals and clinics. More broadly, the Dominican culture is one that gives much consideration to the spiritual etiologies of disease. Local missionary Dan Gower noted that people often seek the services of a spiritual healer, what Thornton would call a bruja (Email Correspondence). This belief in spiritual etiologies of disease is also common in Evangelical circles where brujería is condemned as the work of demons and people instead seek healing through prayer, anointing and casting out demons. Nevertheless, Gower asserts that the residents of Barrio Madrid, “do believe that there is a spiritual aspect to health, but not to the point where it negates the role of doctors or scientific medicine” (Email Correspondence).

**Evangelicalism in the Dominican Republic**

Christianity, broadly defined to include both Catholic and Protestant expressions, is a defining feature of Dominican culture. Thornton argues that, “Christian culture is the
frame within which the Dominican Republic has realized both its own identity as well as its historical and national agency” (1). As a Spanish colony, the Dominican Republic has been a historically Catholic country since the arrival of Christopher Columbus in 1492 (Wipfler 14). The U.S. occupation of the Dominican Republic in the 1920s provided an opportunity for Protestant missionaries to establish themselves. Groups to do so include the Dominican Evangelical Church and the Dominican Episcopal church (Wipfler 15-16). While well over half of Dominicans identify as Catholic, the number who are observant or practicing is smaller1. Currently, the Pentecostal branch of Evangelicalism is the fastest growing religious denomination in the Dominican Republic (Thornton xiv).

Dr. Wipfler explains the success of Pentecostalism in the Dominican Republic through its appeal to the “Latin temperament, especially that of the lower class strata of society” because it offers a highly emotional religious experience in addition to an emphasis on faith healing (21-22). Thornton also argues that Pentecostal congregations “fulfill the desires and meet the material, emotional, and intellectual needs of Dominicans” (3). In Reason to Believe: Cultural Agency in Latin American Evangelicalism, a book that looks at Evangelicalism throughout Latin America, David Smilde makes a similar argument saying that conversion is “undertaken as a solution to persistent life problems” (4). While the Protestant influence in Latin America began with the U.S. occupation, Thornton uses the practical benefits of Evangelicalism for Dominicans living in the barrios to argue that because of Evangelical Christianity’s integration into everyday life, it “is not a separate sphere, perceived as a foreign import, or regarded as an obscure marginal cult”

1 Percentages vary widely. Some sources say 90-95% of Dominicans are Catholic while a survey done in 2004 by the Center for Political and Social studies of the Pontifical Catholic Mother and Teacher University and the Center for Social Studies and Demographics found that “the population was nominally 64.4% Roman Catholic, 11.4% Protestant, 22.5% with no religion and the remainder another religion.”
(4). Corroborating this, Wipfler highlights the fact that within the Dominican Evangelical Church of the 1960s, all of the ministers were Dominican nationals and as a church organization it was largely considered “indigenous” (15). Nevertheless, the usefulness of Pentecostalism for social empowerment in the barrio does not negate the fact that it is still influenced by foreign interventions, often in the form of partnerships with missionaries and short-term mission groups.

**Barrio Madrid**

With approximately 400 homes ranging from tin shacks with dirt floors and plastic lawn chairs to block houses with tile floors and furniture carefully covered to keep the dirt off, Barrio Madrid is a fairly typical barrio, or neighborhood, in San Pedro de Macoris. It has the requisite baseball field, built by a politician during an election year; several churches and many small businesses including a bar, a motorcycle repair shop and several colmados—small stores, usually run out of people’s homes that sell everything from razor blades to rice, Coca-Cola to laundry soap. Men sit outside in the shade playing dominos while women chat with their neighbors. Kids organize games of baseball using water bottle caps as balls and sticks as bats. Motorcycles bounce up and down the half-paved, half-dirt roads carrying up to five people to and from the main town center of San Pedro de Macoris a few minutes away.

Overall the level of education is fairly low, but children do go to school in San Pedro and many in my acquaintance have graduated from high school and gone on to get teaching degrees at the public university. One young woman that I interviewed was home on a break from university in the capital where she is studying engineering. Industry is scarce in the small neighborhood and those who do not own small businesses generally work in
the foreign factories in the Zona Franca in San Pedro, drive a motoconcho—motorcycle taxi, or work as professionals in the city. One woman I spoke with is raising her grandchildren so that her son and daughter-in-law can work long hours in the nearby tourist town of Juan Dolio—a practice that is fairly common in Barrio Madrid and other similar neighborhoods.

**The Dominican Healthcare System**

The Pan-American Health Organization (PAHO) describes the Dominican health system as having two “subsectors”—public and private, with public healthcare being available free of charge, “but with no guarantee of access or quality,” and private being available to those who can afford it (PAHO). While it might seem that this would create a sharp divide between the public and private sectors, in reality, they are intricately linked, with doctors often working mornings in the public system and afternoons in a private clinic (Dr. Alvarez). Patients also often utilize both sectors, preferring private clinics to public primary care centers and hospitals when they can afford them. Nearly everyone I interviewed had a horror story about a visit to the regional hospital, Hospital Regional Dr. Antonio Musa, colloquially called Musa. One young man recounted a time when a doctor who, after learning that he did not have the money for an anesthetic simply ripped off his infected toenail (Heriberto). A middle-aged woman recalled being treated so poorly and being yelled at so severely that she left in tears, feeling far worse than when she had arrived (Guille). There was an overwhelming consensus among the individuals interviewed that going to Musa was beneficial “if you don’t have the money to go anywhere else” (Juana).
The Global Health Initiative describes the Dominican public health system as having “extensive infrastructure” but, “poor quality of healthcare services” with inefficient use of resources—both human and financial—and a lack of planning, supervision and accountability (7). The public health system has recently undergone restructuring via decentralization and USAID lauds the implementation of “user services offices” that have helped to streamline record keeping and facilitate friendlier, more efficient patient care (PAHO, USAID). However, the reality is that at least in San Pedro de Macorís, the public healthcare scene is still inefficient and chaotic. Dra. Alvarez, a local doctor who practices at a small regional hospital confided that while they theoretically have records for their patients, the system is chaos. Practically speaking, she said, “El sistema de records allá es un caos. ... Si yo le pongo por ejemplo, un paciente hoy y le digo ‘venga el viernes,’ ya el viernes el record no parece y le dan otro record nuevo,” “The system of records there [at my hospital] is a mess... If, for example, a patient came in today and I tell him ‘come back on Friday,’ by Friday the record will be nowhere to be found and I’ll make him a new record” (Dra. Alvarez).

The issue of record keeping is anecdotal evidence of a more pervasive lack of organization and supervision. In theory, a centralized delivery system takes care of supplying basic medicine and other necessities to the Unidades de Atención Primaria (UNAP), or primary care clinics. However, when asked whether or not the clinic usually had the needed supplies, the head nurse at the UNAP in Barrio Madrid replied that in reality they often don’t have basic medications and have to send their patients to go buy them for themselves or try to get them from the hospital (Genesis).
Patients in Barrio Madrid had access to several different medical institutions—the two most common being Musa and an UNAP established in the barrio by a local doctor turned politician. People with a somewhat higher socioeconomic status also have access to private clinics that vary in size, specialty and quality of care. A more sporadic, but nevertheless common, way of accessing healthcare is through “operativos”—one or two day clinics set up in the community to provide basic healthcare services. These operativos are often political in nature and are especially common during election years, with candidates financing them in the hopes of gaining votes and positive press coverage. Operativos are also sometimes hosted by UNAPs to target a specific area of health such as women’s health—offering Pap Smears and gynecological exams, or children’s health—targeting deparasitization, vaccination or dental health (Genesis).

This multifaceted approach to healthcare is what allows STMMs to fit comfortably into the healthcare system. Moreover, as a country where most of the population is religious, or at least spiritual, “putting the spirit world to work for them,” (Thornton, 100) religion and health intersect in many interesting ways, some of which will be discussed further in Chapter 4. These two factors makes the reception of faith-based STMMs such as the ones run by the Gregory School of Pharmacy far from surprising.

**STMMs in Barrio Madrid**

A literature review of STMMs found that such groups vary greatly in their duration and organization “from informal one-time trips conducted by a single nurse or doctor, to highly organized repeat missions consisting of a variety of healthcare personnel, logisticians, medical equipment and medications travelling to a region where research and evidence demonstrated a distinct need for outside medical intervention” (Martinuiik et al.
While their duration and purpose may vary, STMMs can be broadly described as "a prevalent and well-accepted means of providing health education, medical care and essential surgeries in resource poor settings by licensed health professionals" (Langowski and Iltis 72). Citing increased globalization, and the transnational nature of health issues, authors have noted an increase in STMM participation, especially among students interested in global health (Langowski and Iltis 72; DeCamp “Review” 91-92; Martiniuk et al. 2). This observation is not only corroborated by the participation of the Florida-based Gregory School of Pharmacy (GSOP) in STMMs, but is further demonstrated in articles published by the GSOP faculty that advise other health professions schools on strategies for incorporating international STMMs into their curriculum (Brown et al. 2012). Although the articles by GSOP faculty insist that a faith perspective is not necessary for STMMs to be useful for the academic and personal growth of pharmacy students, however faith is still the motivation behind their STMMs (Brown et al. 896). In this thesis I argue that faith-based STMMs should be considered differently than secular STMMs as the influence of religion impacts the ethics of the intervention.

Since the STMMs run by the GSOP are faith-based STMMs that work closely with local missionaries and pastors who also receive other types of non-medical short-term missions, it is important to consider the ethical questions pertaining to non-medical short-term missions². Jeffrey Raines, in his PhD dissertation, An International Perspective on Short-term Missions, spoke with the "receivers" of short-term missions in order to gain an

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² Non-medical short-term missions are almost as difficult to define as STMMs as they vary in duration, activity, philosophy and size (Raines 10). However, in general they refer to trips undertaken by a church or other religious group, such as a non-profit organization, that seek to "proclaim Christ in word and in deed" (Raines 11). This can happen through direct evangelism, building projects, the hosting of Vacation Bible Schools, teaching in seminaries, etc. (Raines 11).
international perspective on mission trips that are often integral to the format of Western churches. In doing so, he came across many of the same ethical pitfalls that I have in researching STMMs, including several that are unique to religious missions. Raines highlights the difficulty of evaluating spiritual projects like mission trips, saying, “Determining the ‘effectiveness’ of any ministry activity is notoriously difficult—effective to whom, by what criteria and whose criteria?” [emphasis his] (14). He also found that a “major area of critique regards the development of dependency or paternal relationships” between mission teams from high-income countries and receiving countries (26). This dependency also spills over into issues of privilege, wealth and even race, as “many local people simply do what a ‘white’ guest asks out of a desire to please and to potentially access Western resources” (34). While this quotation is in reference to response to evangelistic appeals, my interviews with local missionaries in the Dominican Republic show that the privilege of light skin and/or Americanity can greatly influence the response of local communities to visiting mission teams, both medical and non-medical.

The ethics of such interventions are unfortunately often left interrogated, especially when the missions are faith-based. A personal reflection below demonstrates that STMMs are not ethically neutral enterprises:

“The situation in which ethical concerns regarding short-term medical missions came to light for me was in casual discussion with other medical mission participants. Our conversation was not academic nor was it filled with ethical theory, but as we asked each other questions like ‘Will that man we gave atenolol to be able to get a refill so his blood pressure doesn’t spike
again? or “How long do you think it will be before everyone has parasites again?” we were making inquiries about the ethicity of our work, questioning whether or not we had done enough and if we had done it in the right way. However, that probing was uncomfortable because it questioned the very core of what we had spent so much time, effort and money doing. So we quickly reassured ourselves that we had done the best we could and the rest was left in God’s hands” (Author’s personal reflections).

While ethics may not be formally addressed during an STMM, questions about efficacy and sustainability lie just below the surface. Moreover, this reflection highlights the fact that ethical evaluation in faith-based STMMs is especially important, because participants, like myself, often fall back on language of “God’s purpose” or “God’s sovereignty” when speaking of outcomes, leading to a lack of critical thought and willingness to investigate the ethics of the short-term medical missions.

Faith-based STMMs such as those run in the small community of Barrio Madrid in San Pedro de Macoris, Dominican Republic by the Gregory School of Pharmacy at Palm Beach Atlantic University, have different goals than secular STMMs. These goals, which include “sharing the love of God with people in need” (Jay Jackson) and “providing spiritual care” (Mara Poulakos) as well as strengthening the outreach of the local church in the community, mean that the metrics for the success of faith-based STMMs are often more obscure than those for non-religious STMMs. Nevertheless, faith-based STMMs should be
held to the same, if not higher, ethical standards as any other STMM, especially considering the potential pitfalls that religious association brings.

While as of yet, there is not a universally accepted rubric for the ethical evaluation of STMMs, Matthew DeCamp proposes seven ethical principles that he believes should govern STMMs. These principles are (1) collaborative partnership that empowers the local community, (2) fairness in site selection, (3) commitment to benefits of social value, (4) education of the local community and team members, (5) building the capacity of local infrastructure, (6) evaluation of outcomes and (7) frequent ethical review (DeCamp “Review” 97-99). In this thesis I will use DeCamp’s model to examine the ethics of the STMMs run by the GSOP in the Dominican Republic using information gathered through interviews and surveys with participants from GSOP as well as community members, local doctors, missionary hosts and pastors as the basis for my analysis. Moreover, I will show the ways in which the religious component of STMMs complicates the ethics of DeCamp’s model. Lastly, I will situate STMMs within the broader narrative of empowerment and intercultural competence, proposing an ideal model for ethical and empowering interactions between STMMs and the communities in which they work.

Outline

In Chapter 1, I will provide an overview of the research I conducted with all five stakeholders: the community in the Dominican Republic served by STMMs, the missionary hosts who coordinate STMMs, the pastors of the church that receives STMMs, the Dominican doctors who help facilitate the STMMs and the GSOP faculty and students who participate in traveling to the Dominican Republic to conduct STMMs. The development of questions, the interview and translation process, as well as the roles of these five groups
will be discussed. Chapter 2 will provide an overview of general STMMs and will then discuss the goals of the GSOP’s STMMs, interrogating the nuances that differentiate faith-based STMMs from secular STMMs. I will use information gathered from interviews and surveys to show how the addition of the local church and missionaries as stakeholders in STMMs complicates their overall goals, shifting the focus from health outcomes to less measurable spiritual outcomes. An ethical review of the GSOP’s STMM model will be detailed in Chapter 3 as I use DeCamp’s seven criteria to evaluate its successes and failures. I will also offer suggestions as to how the GSOP could improve in those areas. In Chapter 4 I will discuss the ways in which religion and health intersect in the Dominican Republic, demonstrating how that intersection complicates the ethics of interactions between the community and STMMs. Using religion, knowledge and intercultural competence, Chapter 5 engages in questions of ongoing practice and discourse, offering recommendations for the future by proposing a model in which STMMs can interact ethically with the communities they serve, reaching the ultimate goal of empowering those communities to name and address their own health concerns.
Chapter 1: Research Methods

Research for this thesis was done in two major parts. First, with funding from the Duke University Center for Latin American and Caribbean Studies, I traveled to the Dominican Republic to conduct interviews with Dominican stakeholders in short-term medical missions (STMMs). These stakeholders included four major groups of people: (1) members of the Barrio Madrid neighborhood of San Pedro de Macoris, the community in which STMMs were conducted, (2) local American missionaries who facilitated and coordinated STMMs with groups from the U.S., (3) pastors of a local church that, in conjunction with local missionaries, hosted STMMs on a regular basis, and (4) Dominican healthcare professionals living in San Pedro de Macoris. The second stage of research involved surveys as well as email conversations with STMM participants—faculty and students from the Gregory School of Pharmacy at Palm Beach Atlantic University (GSOP). All interview questions, methods and consent processes were developed in conjunction with my research and thesis advisors as well as the Duke Institutional Review Board. A complete collection of interview and survey questions is available in Appendices A-C.

Research Site

I chose Barrio Madrid as my research site for several reasons. As a community with strong ties to missionaries who regularly host STMMs, the community usually receives 1-2 STMMs per year from the GSOP. This consistency in contact meant that I was more likely to interview people with experience interacting with STMMs led by teams from the U.S., specifically those from the GSOP. On a more personal and practical level, my ties to the community from previous trips meant that friends and acquaintances were eager to help.
me with my research, recruiting community members for interviews and accompanying me as I walked through the neighborhood. In total, I interviewed 28 community members living in Barrio Madrid including both people who were members of the host church and those who were not. Respondents were overwhelmingly female, ranging from young twenties to mid seventies; only 2 males, both of whom were in their twenties participated. Such a skew in the gender of interview participants may seem undesirable, however, it is generally the women of the barrio who participate in STMMs and manage their family’s overall health, therefore, the sample is fairly representative of those community members who make healthcare decisions.

Data Handling

I conducted semi-structured interviews, using the questions found in Appendix A as my guide. The length of the interviews ranged between 20 and 75 minutes, depending on how much informants shared. Interviews with key informants such as local physicians and pastors were on the longer end, as I asked them more questions. In a couple of cases, notably my interviews with the local physicians, I concluded the interview by asking them questions that were not necessarily relevant to my research, but that had come up during my time there. These included questions about medical training in the Dominican Republic and the incidence of tuberculosis in the region. Before every interview, I asked the informant’s permission to take notes and record the conversation. All of the informants agreed to being recorded, both via my note taking and with a handheld device. At the end of every interview day, I transcribed my notes into a Word document, making note of where things were unclear. I then went back and listened to the recording, filling in information that I had missed. I also transcribed in Spanish quotes that I found particularly
helpful or compelling. Throughout my time in the Dominican Republic, I used a Word document to make note of recurring themes in my interviews as well as keep track of general questions that I asked my assistants and hosts in more informal conversations.

**Overview of Questions Asked**

Questions for members of the Barrio Madrid community centered on their experiences with healthcare in their community as well as questions that sought to understand the ways in which they perceived and utilized STMMs. As a white American who has previously assisted with the GSOP STMMs in Barrio Madrid, I was conscious that informants’ answers might have been “skewed to please” meaning that my association with STMMs might make informants reticent to criticize them. In an attempt to combat the filtering of negative comments about STMMs, I was careful to frame my questions in a consistent way, first asking about the positive and negative aspects of where they usually seek healthcare and then asking about the positive and negative aspects of STMMs.

Using Gretchen Schumacher’s *Culture Care Meanings, Beliefs and Practices in Rural Dominican Republic* as a guide, I asked questions about what she calls “meaning of care,” which I find more helpful to call “healthcare values” as they are the values that community members enact when seeking healthcare. These healthcare values included family presence during illness, the importance of a caregiver paying attention to them as a patient, and the role that respect plays in the provision of healthcare. My interviews also included questions about health-seeking behaviors such as questions about consulting with neighbors for health advice and the perceived costs and benefits of utilizing the public and private healthcare systems.
In seeking to understand how short-term medical missions fit into the community’s healthcare paradigm, I asked questions like, “How does the care you receive from an STMM compare with the care you receive where you usually seek medical care?” and, “How do you feel after receiving care from an STMM?” Because *operativos* (the name Dominicans give the short-term clinics run by visiting STMMs) run by political and religious groups, foreign and domestic, other than the GSOP are common in Barrio Madrid, some of my informants used their experiences with other groups to answer my questions about STMMs. While those answers are not directly applicable to the specific question of the ethics of the GSOP STMMs, they do provide a fuller picture of the functioning of the healthcare system in the Dominican Republic and the broader role of both foreign and domestic STMMs. Throughout the rest of my analysis, I use their interview responses accordingly.

Information was gathered from Dan and Shana Gower, who are local missionaries, in an informal manner throughout my time living with them. Having lived near and worked in Barrio Madrid for seven years, they provided a mix of U.S. and local perspective, making them an invaluable resource for linguistic and cultural questions that often lingered after a day of interviews. Specifically, the Gowers provided assistance in translating interviews as well as explaining aspects of the local healthcare system that my informants referenced. In a more structured interview, I asked about their views of the Dominican healthcare system including, “What do you see as the role of the public healthcare system in the DR?” “What do you see as the biggest deficiencies in the healthcare system?” and “What do you see as positive aspects of the public healthcare system?” With 10 years of experience hosting short-term mission teams, including medical missions, they provided a unique perspective
on the STMMs as I asked them about their participation in hosting STMMs and the purposes and goals of STMMs from their point of view.

Local pastors, Alex and Guillermina Diaz, have strong ties with the Gower family, having worked in partnership with them for 10 years. Short-term mission teams, medical and non-medical, have been coming to their church in Barrio Madrid for over 10 years. This long-term participation with STMMs as well as their role in organizing and hosting STMMs made them key informants for my research. The Diazes first participated in my standard interview for community members, providing information on their healthcare experiences and values both within the existing system and with STMMs. In an extended interview, I sought information regarding their long-term involvement with STMMs, asking questions like, “Why did you start hosting STMMs at your church?” and “What is the purpose or goal for your church in hosting STMMs?” They also offered their vision for the purpose they would like STMMs to serve in their community in the future.

The Dominican healthcare professionals I interviewed fall into two groups. The first includes a nurse and two doctors who work at a local public health clinic in Barrio Madrid. After many community members referred to the clinic as their primary source of healthcare, I wanted to get more information on the services they offer as well as their interactions with STMMs that visit the community they serve on a regular basis. I asked the nurse to provide a brief history of the clinic, as well as an overview of the services offered. To learn more about the public healthcare system, I asked about the payment structure of the clinic as well as about how the clinic is supplied. In interviews with the nurse as well as with clinic doctors, I asked questions about healthcare values that community members had highlighted as important. For example, I asked “How do you, as a
healthcare professional, pay attention to your patients?” “Do you believe that it is important to connect with your patients emotionally?” and “Do you think it is important to explain the reason for a certain treatment or medication to your patients?” I also asked about their experience and involvement with STMMs, foreign and domestic.

The second group of healthcare professionals that I interviewed were doctors who have consistently worked with STMMs from the Gregory School of Pharmacy over the past four years. The first part of the interviews with Dra. Cruz and Dra. Alvarez consisted of the same questions about healthcare values that I asked the clinic healthcare providers. Then, because of their long-term contact with the team from the GSOP, I asked specific questions about their involvement and perspective on STMMs. I asked questions like “Why do you think the GSOP participates in STMMs?” “What are positive and negative aspects of STMMs?” and “Do STMMs that come from the U.S. understand the needs of the communities in which they work?” Additionally, Dra. Cruz and Dra. Alvarez helped to clarify some things that other informants had left vague with regards to the healthcare and insurance systems. I also asked them questions about their training and the daily work in a rural hospital outside of San Pedro de Macoris.

Having established relationships with participants from the Gregory School of Pharmacy during past STMMs, during which I served as a translator and assistant, I was able to contact students, faculty and alumni via Facebook and request that they participate in a survey regarding their experiences with STMMs. Two faculty and three alumni responded to the online, four-part survey. The first section of the survey asked questions about the number of times participants had traveled to the Dominican Republic as part of an STMM and what their role was on those trips. Planning and logistics questions
regarding site selection, and the history of the trips made up the second section. The third section asked questions like “What are the stated goals of the STMM for GSOP students/faculty who are participating?” “What are the stated goals of the trip for the communities where the STMMs serve?” and “Do you feel like these goals are met?” Questions that encouraged self-reflection made up section four, and asked about the personal and professional impact of the trip as well as individual purposes for participating in the trip.

Healthcare Values in Barrio Madrid

To begin my interviews, I asked questions regarding healthcare values, based on Gretchen Schumacher’s ethnonursing study, *Culture Care Meanings, Beliefs, and Practices in Rural Dominican Republic*, which found three major themes or values, “(a) family presence is essential for meaningful care experiences and care practices, (b) respect and attention are central to the meaning of care, and (c) rural Dominicans both value and use generic (folk) and professional care practices” (97). My informants confirmed the importance of family presence, agreeing that when family is present, “*uno se siente apoyado,*” “you feel supported” (Isabella). Moreover, they highlighted a lack of family presence during illness as negative, saying that it would make them feel “*afligida, deprimida,*” “afflicted, depressed” (Esmeralda).

Community members also confirmed that respect was extremely important in patient-provider relationships with several informants highlighting the importance of mutual respect (Mabelin; Natalia). When asked how one shows respect, most respondents pointed to an overall attitude, the use of specific words such as “*por favor,*” and a friendly or not harsh tone. One informant said that treating someone with respect means speaking
“con amor” or “with love” (Antonio). Healthcare providers who pay attention to their patients were also valued. Informants described “paying attention” in a variety of ways including spending time with the patient, explaining things rather than simply handing the patient a prescription and body language. One woman said that when a healthcare provider does not pay attention, “uno sale loca, deprimida” “you leave crazy, depressed” (Lismeiri). Another informant said that in paying attention to their patients, healthcare providers contribute to the “salud emocional” or “emotional health” of their patients (Heriberto).

The use of folk remedies was not as commonly seen, though that could be a deficiency of the question and not reflective of a lack of use. The first several informants appeared to be confused when I asked if they sought healthcare advice from people other than their healthcare providers. My assistant, knowing that many of them frequently use teas and other food-based remedies offered those as suggestions, prompting subsequent informants to point to their mothers and grandmothers as people with what Schumacher might consider “folk” knowledge. The lack of emphasis on folk remedies could also be due to the fact that my research area was much more urban, giving community members relatively easy access to biomedical healthcare facilities while Schumacher’s research was conducted in a more rural area where folk traditions might more strongly persist.
Chapter 2: Short-Term Medical Missions

Introduction to STMMs

As the pastor of a Dominican church that regularly hosts short-term medical mission (STMM) teams so eloquently put it, teams who come to the Dominican Republic are concerned about the poverty, inequalities and lack of access to adequate health services that face many low-income Dominicans and want to “aportar un grano de arena a la situación difícil de los más necesitados” or “contribute a grain of sand to the difficult situation of the people with the most need” (Alex Diaz). Scholarly literature on STMMs agrees that the motivations of the many health professionals and students who participate in these interventions are “laudable” (White 851), “altruistic” (DeCamp “Scrutinizing” 21), and come from a desire to address the increasingly visible health disparities around the world (Langowski and Iltis 72). But what exactly is an STMM, and are the outcomes of such interventions always as beneficial and laudable as the intentions?

The definition of “short-term” in medical missions varies, with some sources using it to refer to interventions that last anywhere from 1 day to 2 years, however, the majority of STMMs occur over the course of 1-4 weeks (Martiniuk et al. 3). The structure of STMMs is as varied as the organizations that facilitate them. A group of doctors, nurses and pharmacists traveling to rural Nicaragua may simply provide “responsive” or acute care, setting up an ambulatory clinic and consulting with patients who exhibit a variety of simple medical needs such as upper respiratory infections, parasites, joint pain, high blood pressure or STIs. If a dentist or surgeon is part of the team, tooth extractions and minor surgeries such as hernia repairs or wound closure may also be a part of the STMM. Some STMMs are more focused on a single issue such as cleft lip and palate repair, vaginal fistulas
or child vaccinations (Langowski and Iltis; Martiniuk et al.). A trip organized by a medical school or university might spend time investigating local healthcare systems, specifically treating tropical diseases or targeting a communicable disease like AIDs in addition to providing care. Overall, STMMs seek to meet the health needs of developing countries by exposing health professionals and students to those needs, distributing medication and providing education along the way (DeCamp; Crump and Sugarman).

While the goal of becoming educated about and decreasing global health disparities are indeed laudable, scholars have recently observed that the contribution of a “grain of sand” that these STMMs try to make may in fact be accompanied by a sandstorm of ethical implications that many short-term medical missions (STMMs) have not adequately confronted. Concerns over sustainability, cultural competency, and the prioritization of treatment over prevention have led ethicists and concerned STMM participants to highlight a collaborative approach with the building of local infrastructure as new ethical goals for STMMs (Martiniuk et al; DeCamp).

The GSOP Model

The Palm Beach Atlantic Gregory School of Pharmacy (GSOP) first began sending STMMs to the Dominican Republic in 2006 as a way of fulfilling their mission of “Pharmacy with Faith—Preparing Servant Leaders of Tomorrow” (Palm Beach Atlantic University). As a faith-based school, the purpose of STMMs for GSOP is not only to provide medical care, but also to “share the love of God with people in need” (Jay Jackson) and to “provide spiritual care” (Mara Poulakos). The trips are designed to develop servant leadership in the student participants as well as provide them with “direct interaction with diverse patient populations in a variety of practice settings” as stipulated by the Accreditation
Council for Pharmacy Education guidelines (Chahine and Adwoa). In practice, these goals manifest themselves as pharmacy students rotate through various tasks during short-term clinics. Their model of STMMs consists of one to two day general health clinics, usually hosted at by a local church or school, where visiting medical professionals—Doctors of Pharmacy and pharmacy students—bring their expertise and medications to work alongside local doctors to provide basic care to the community. The team usually travels to four or five different communities, some in semi-urban barrios, like Barrio Madrid, and others in more rural areas where sugar cane is cultivated known as bateyes.

In general, as a patient consults at a short-term clinic run by GSOP, she will first have to wait a while, as community members usually turn out in droves, some because they are genuinely in need of medical attention, some because the clinics present an opportunity to socialize and obtain medications free of charge. As she waits, she will hear a group of pharmacy students give a talk or “charla” about health issues such as nutrition, STIs, blood pressure control or diabetes. Her first stop one-on-one with a healthcare provider will be in triage, where a pharmacy student working with a translator will take her history, vital signs and record her chief complaint. The patient will then consult with a local doctor who has volunteered to be a part of the STMM for the week. There she will discuss her chief complaint in more detail, undergo additional examination if necessary and be prescribed any medications that she needs. Pharmacy students, under the supervision of their faculty, will compound and prepare medications and then fill her prescription. She will then be counseled by a pharmacy student or faculty about the proper way to take her medications as well as potential side effects. At this point, she might hang around and listen to another charla, socialize with other community members as her children play with bubbles or the
new toys given to them by the team, pray with the pastor or one of the team members or simply head home with her medications.

**Goals for Short-Term Medical Missions**

Many of the questions I asked participants and facilitators of STMMs were directed at the core question of purpose. The goals for any endeavor are generally a good metric of success or failure, since they provide a standard to be reached. In interviews with missionary hosts, local pastors and pharmacy school participants, I discovered that the range of goals was wide, and often not well defined. In this section, I will use interview and survey responses as well as articles published by faculty and administrators from the GSOP to illuminate the purposes behind STMMs from the perspective of all four stakeholders: the GSOP, the host missionary, host pastor and church as well as the community served.

The GSOP views STMMs as a way for their students to be directly involved in patient care as well as an opportunity for students and faculty to grow spiritually through team devotionals and evangelism (Elias Chahine; Jay Jackson; Matt Bamber). From an academic perspective, STMMs allow pharmacy students to experience medical care in a setting that is outside their comfort zone, often dealing with diseases that are not common in the U.S. One participant said, “I grew professionally in not having all of the latest and technology at my disposal. I learned how to make do with what I had in order to help patients” (Jay Jackson). For several participants, faith and spirituality provided the motivation for going as well as an important part of the care process (Elias Chahine; Jay Jackson; Matt Bamber). More generally, trips also teach participants about the importance of culturally competent patient care, compassion, and clinical and communication skills (Elias Chahine; Deanna Boone; Matt Bamber).
According to an article giving advice about conducting STMMs, the GSOP believes that “medical mission trips are the most effective educational tool for shaping students’ attitudes, values and beliefs” (Brown, Brown and Yocum 895). Altruism, passion for service, humility and teamwork are all values fostered through STMMs (Brown, Brown and Yocum 895). Pharmacy students, faculty and administration are open about the fact that as participants, they often feel like they receive more benefit from these trips than those they serve (Brown, Brown and Yocum 900; Deanna Boone). In reflecting on the trip, several participants expressed a change in perspective having witnessed poverty and served those without access to good medical care (Jay Jackson; Mara Poulakos; Brown, Fairclough and Ferrill 1255). One pharmacy student expressed it this way: “[the STMM] allowed me to have a greater appreciation for my current blessings. It also allowed me to come to realize that medical missions work—both short and long-term—is a calling that the Lord has put on my life. It taught me to appreciate different cultures and grow to appreciate and love those who are different from myself” (Matthew Bamber).

Pastors Alex and Guillermina Diaz have pastored Iglesia Emanuel 3ra for over 12 years and had their first encounter with a short-term medical mission 10 years ago. Through a partnership with American missionaries Dan and Shana Gower, Emanuel 3ra has come to be involved in short-term missions, including many medical missions. Says Alex, laughingly, “somos identificado tanto que alguien gente dicen ‘la iglesia de los Americanos’” “Our church so identified [with mission teams] that some people call us ‘the American church.’” For the church, the purpose of STMMs is two-fold. First of all, it helps the church identify with and be involved in the lives of the people in their community, providing a service that helps community members gain an improvement in their
health. Secondly, in hosting STMMs, the church is able to show the love of God to the community, especially to those who would normally not be comfortable coming to the church for a service (Alex Diaz). Overall, while they recognize that STMMs from the U.S. bring much-needed resources to their community, as long-term members of the community, they would like to see long-term solutions to health problems.

Dominican missionaries Dan and Shana Gower hosted their first short-term medical mission in the Dominican Republic in 2000, “because Jack [the director of our missions organization] told us they were coming.” Their initial hosting of STMMs was part of their job description, but since then, they have hosted many more STMMs, mostly through established relationships, such as the one with the GSOP. While the Gowers acknowledge the service that STMMs offer to the community in the provision of medical care, they see the main purpose of STMMs as supporting the local church and children’s centers that the Gowers partner with in reaching out the community. Says Dan, “The people are going to get their health care anyway, though in some places they’re [STMMs] are a real benefit, but the first thing is supporting the churches and children’s centers where we work.”

When asked how the community viewed STMMs, both the Diazes and the Gowers agreed that they are viewed very positively, asserting that people tend to trust American health care providers and medicine more than the Dominican counterparts (Alex Diaz, Dan Gower). While in interviews community members did speak very highly of the medications that the teams bring, they also made no distinction between the qualifications of local healthcare professionals vs. American, though a few did note that often STMMs involve students who are still learning (Eva; Esmeralda; Diana). In general however, STMMs were viewed by members of the local community as being successful in their goals which most
people articulated as providing medication and health services to “benefit the poor community” or to “bring the doctors to the people” (Eva, Heriberto, Juana). Several people brought up the fact that STMMs tend to focus on kids, bring the community together and are “por amor” or “out of love” (Tuti, Salena).

The visiting pharmacy school, American missionaries, local pastors and community all have different stakes in STMMs. They have a variety of goals that sometimes overlap, but often diverge based on their own interests. All four stakeholders acknowledge that while a major goal of STMMs is to provide medical services to a Dominican community, STMMs also have subtler goals such as the education of pharmacy students, support of local churches and ministries and community education. It is important to keep in mind all of these goals when evaluating the ethics and effectiveness of STMMs. As Dan Gower said, STMMs “at best help alleviate some of the results of the problems in the Dominican healthcare system, but they don’t solve the problem or even contribute to solving the problem because it’s so deeply rooted.” Nevertheless, STMMs continue, perhaps because they succeed in reaching some of their less obvious goals.
Chapter 3: A Model for Ethical Evaluation

This chapter focuses on the ethics of short-term medical missions (STMMs), first providing a background for the ethical questions that have been discussed in the academic and lay literature. After giving a brief outline of Matthew DeCamp’s flexible, yet comprehensive rubric that outlines ethical principles that STMMs should meet, I will then apply that rubric to evaluate the ethical success and shortcomings of the STMMs conducted in the Dominican Republic by the Gregory School of Pharmacy (GSOP).

Ethical Thought Surrounding STMMs

Despite an encouraging move toward self-evaluation among healthcare providers involved in STMMs, the discussion of ethics in STMMs remains largely relegated to the academic realm, with few resources available for organizations and individuals to use in assessing the ethics of their specific STMM interventions. Additionally, there has been a lack of large-scale attention to the ethical issues surrounding STMMs, likely, as DeCamp suggests in Ethical Review of Global Short-Term Medical Volunteerism, due to the fact that “many individuals engaged in short-term outreach consider their activities intrinsically noble or altruistic and thus not requiring of ethical scrutiny” (“Review” 92). Using the debates that have surrounded research ethics in developing countries as a jumping-off point, several scholars have suggested that “it is time for clinical ethics to being exploring the ethical problems encountered by medical volunteers in developing countries and suggesting analysis methods that account for this unique context” (Wall 81; DeCamp “Review”).

Literature and scholarly articles regarding the ethics of STMMs abound, taking the form of personal reflections published in journals by returning healthcare providers,
guidelines for best practices put forth by organizations, or critiques that focus on a specific type of STMM. While often insightful, these articles pose two opposite challenges in their usefulness for informing and evaluating the ethics of individual STMMs. First, the ethical guidelines proposed are often extremely specific and incredibly detailed. For example, though it makes many relevant points regarding the ethical pitfalls of STMMs, such as disempowerment and questions of beneficence, *Operating Responsible Healthcare Missions* proposes many highly particular guidelines including a color-coded triage system for children, models for birth attendant training and tools for assessing protein energy malnutrition (Seager 2010). While useful in some contexts, these guidelines are not necessarily applicable to all STMMs and wading through a large volume of information in order to find the pieces that are salient may be daunting for the average STMM participant. On the other end of the spectrum, many ethical critiques of STMMs are extremely general, bringing up issues of cultural misunderstandings, lack of community involvement in decision-making and reduction of confidence in local providers (Langowski and Iltis; Bajkiewicz; Wall). These offer generic solutions, encouraging pre-trip preparation, cross-cultural learning and moves toward sustainability, but do not provide a rubric by which individual STMM sending organizations can evaluate their work.

This gap between specific guidelines and generic critiques is filled by DeCamp’s synthesis of many ethical principles that he proposes should be used to guide STMMs “toward global health equity through an expression of mutual caring” (“Review” 97). Stressing that STMMs and other global health work is not an ethically neutral enterprise, DeCamp offers a flexible, yet well-defined rubric that empowers STMM sending organizations to self-evaluate the ethical implications of their work according to seven
ethical values (DeCamp “Review”). These seven values can be divided into three ethical themes: (1) fairness, (2) community empowerment and (3) self-reflection.

Fairness is the smallest category with only one principle that fits neatly within it, fairness in site selection. This emphasizes the need for STMMs to be conscious that in selecting a target community, other communities are being excluded. It also cautions against inappropriate site selection for political or monetary gains.

Empowerment encompasses the value of collaborative partnership as collaboration implies equality and emphasizes the need to empower the local community and “eliminate the sense that they are mere recipients of aid” (DeCamp “Review” 97). The idea of a partnership also implicates values such as honesty and understanding, which precludes a healthcare professional from working outside her area of expertise and makes STMM participants responsible for linguistic and cultural knowledge. Also included in this category is the commitment to benefits of social value. With empowerment in mind, the definition of benefits should be largely left to the community being served, even when they do not align with the desires of STMM participants. DeCamp does allow for benefits to STMM volunteers, such as professional education and gaining of cross-cultural experiences, “so long as they are in line with the trip’s collaborative purpose toward greater global health equity through mutual caring” (“Review” 98). Education of the local community and team members is the third principle under this heading, again emphasizing the empowerment of the local community in “ensuring that education operates in both directions” (De Camp “Review” 98). The fourth principle encourages building the capacity of local infrastructure through healthcare worker training, building clinics locally and
empowering the local community’s voice in naming and proposing solutions to local healthcare challenges.

Self-reflection is the category into which the principles of evaluation of outcomes and frequent ethical review fall. DeCamp argues that just as clinical research is outcomes-based, the outcomes of STMMs should be evaluated in a concrete way based on their justification for the trip (“Review” 99). Similarly, engaging in frequent ethical review including involved and independent reviewers allows STMMs to consistently be self-reflective and ensure that they are meeting their objectives and acting in an ethical manner.

**Applying an Ethical Model**

In this section, I use scholarly articles written by the GSOP faculty, and survey responses from STMM participants from the GSOP to evaluate the STMMs conducted by the GSOP in light of DeCamp’s seven ethical principles. Additionally, I will offer suggestions as to how the GSOP could move toward a more ethical model in each area. DeCamp introduces the concept of guidelines with the idea that “all global short-term medical volunteer trips should develop their own statement of purpose geared toward global health equity and mutual caring” (“Review” 97). With this in mind, I asked students and faculty from the GSOP about the stated goals for STMMs, both for the faculty and the students. While their responses reflected a purpose centered on the themes of spiritual growth and care, evangelism, the provision of healthcare services, and the development of clinical and leadership skills in the GSOP students, they lacked any reference to outcomes, benchmarks or other measurements of success. This lack of clarity of purpose with
specified outcomes makes the success or failure of these trips, both pragmatically and ethically, challenging to evaluate.

**Fairness in Site Selection**

Decisions regarding site-selection for STMMs are made by the faculty and administrators of the GSOP. Dr. Chahine, a faculty member who has led STMMs to the Dominican Republic explains that they make decisions about where to go, “by partnering with missions organizations at an annual mission conference” and through previously established connections (Elias Chahine). While they have sent teams to the Dominican Republic since 2006, the GSOP has recently begun diverting teams elsewhere, sending a team to the Amazon region of South America instead of to the Dominican Republic. A student at GSOP shared that she tried to organize a trip to the Dominican Republic in 2010, but the administration of the GSOP, with no explanation, would not allow it (Deanna Boone). Instead of participating in the official GSOP trip that year, she gathered other pharmacy students, pharmacists and faculty who had previously been to the Dominican Republic and ran a trip herself. She recounts that experience,

“I think the large reason we undertook the endeavor is because I saw a basic disregard for a consistent relationship. PBA [GSOP] had been for nearly 5 years and to just simply quit wasn’t an option for me and my friends. It didn’t seem right. There was one patient that made me believe that. A mid 30 to 40 year old man my first time in the DR. I remember checking his sugar and it was in the 400s. In the US, that’s borderline criteria for hospital admission. And then I realized he was
excited and proud of it. He explained that every year PBA comes and brings his metformin and he takes it and its been going down. Of course he probably need more intense regulation and it was still really high but in that moment I realized there were people that depended on us. So the next year to not go back and bring him metformin seemed ridiculous to me. He was the one main reason I didn't give up" (Email Correspondence, Deanna Boone).

While the GSOP is not politically or monetarily profiting from the locations that it chooses to send STMMs, it also appears that they lack a clear rationale for choosing specific target communities. Moreover, much of the literature regarding ethics in STMMs emphasizes the need for continued partnership in order to reach long-term goals (Bajkiewicz; Montgomery; Wall). Inconsistency in site-selection by the GSOP, therefore is cause for concern ethically.

**Collaborative Partnership**

Working with the permission and assistance of a local church and speaking with local doctors about the health needs of the community, at first glance, it would appear that the GSOP's relationships with host missionaries, pastors and communities is indeed a collaborative partnership. The GSOP participants have been responsive to input from local physicians while “in the field.” For example, on one particular day during the operativo, the doctors were seeing a lot of patients with high blood pressure. In a community where the major food staples are highly salted rice dishes, Coca-Cola and coffee, the physicians realized that much of the high blood pressure likely resulted from diets high in sodium and
caffeine. As they continued to educate individual patients about how changes in diet could help lower blood pressure, they suggested that some of the students gather waiting patients and give a presentation about healthy eating habits, including ways to naturally reduce blood pressure through diet change. The team followed their advice and integrated that talk into subsequent clinic days, even continuing to use it on later trips.

In terms of being culturally and linguistically knowledgeable about the community the serve in, the GSOP takes measures to prepare its students. In a set of guidelines for pharmacy led-mission trips that were published by GSOP faculty, they advise “inquire about the medical needs of the people that your team will be serving” and “investigate common disease states in the intended destination” (Brown and Ferrill “Part 1” 752). Students who are participating in the STMM as part of their Advanced Pharmacy Practice Experience (APPE) rotation are required to present on the country to which the team will be traveling, educating fellow participants on the geography, demographics and culture (Brown and Ferrill “Part 2” 1112). Linguistically, they encourage students traveling to Spanish-speaking countries to enroll in a course entitled “Spanish for the Pharmacist” prior to participating in an STMM. This practical pre-training equips participants for triaging patients as well as counseling them about their medication. If a participant does not speak Spanish, local missionaries, other volunteers or hired translators who are fluent are available to translate. Moreover, in partnering with local physicians and having them serve as the primary caregivers and prescribers, the GSOP creates a sort of “safety net” so that even if triage misunderstands the patient due to linguistic or cultural differences, the diagnosing and prescribing physician is Dominican.
While the GSOP admirably educates its STMM participants and partners appropriately with translators and local physicians, when evaluating the idea of a “collaborative partnership,” it is important to keep the idea of equality in mind. As Steve Corbett and Brian Fikkert discuss in their book *When Helping Hurts*, arriving in a community and asking, “What do you need?” gives privilege to the foreign visitors and implicitly assumes that the local community has nothing to offer (126). While asking for the input of the community may appear to be collaborative, when it is done in such a way that is disempowering, the long-term effects are often extremely detrimental. Rather than asking a community what they need, Corbett and Fikkert advocate an asset-based approach that focuses on assessing what the community already has, only using outside resources to fill in when necessary. They say, “indeed, the very nature of the question—What gifts do you have?—affirms people’s dignity and contributes to the process of overcoming their poverty of being” (Corbett and Fikkert, 126) Encouraging the community to take an inventory of the assets they have and may have been underutilizing allows for the establishment of a more equal partnership in which both the visiting STMM and the local community have something to contribute.

One way that the GSOP could apply this asset-based approach is to partner more closely with local healthcare providers in the planning process. Partnering with the local clinic in Barrio Madrid and assisting with their health programs would be one way enable the community utilize the assets already present. Instead of approaching STMMs with an attitude of “here’s what we can bring,” a more learner-centered approach would be helpful. For instance, I lived near Barrio Madrid over the course of several summers, every year spending time in the barrio with STMMs. Only in doing research there and
interviewing community members about the places that they seek healthcare did I become aware of the local UNAP (public clinic). In talking with the nurse in charge of the clinic, I found that many of the UNAP's goals, including community education, align with the goals of the STMMs. This sort of learning did not take place while I was part of the larger STMM, rather it required that I be on my own, looking for ways to learn about the local healthcare system. While a pre-STMM trip may add to initial costs, if STMM leaders could travel to the Dominican Republic and spend time meeting with local healthcare professionals and community leaders about their desires and vision for the future, such collaboration could promote local ownership of the project and create better long-term outcomes, both in terms of empowerment and health.

In my interviews with local community members, I found that they access healthcare services in a rather piecemeal way. When they have the money, they generally prefer to utilize the services of a private clinic. For routine care, most informants said they utilize the local UNAP and for emergency care or the services of a specialist, almost everyone goes to Hospital Musa. Add in STMMs conducted by foreigners, political operativos and public health campaigns and the services available to the community are partial and often redundant. Collaboration between the local UNAP and the STMM could support the services that they already provide, helping to build local infrastructure. Moreover, while the STMM could temporarily help to relieve personnel shortages at the UNAP in regular consults, they could make a longer-term impact by supplying pharmaceuticals or helping with a specific community health campaign that the UNAP would like to host. Additionally, a longer-term partnership with the local healthcare system could benefit the GSOP by providing opportunities for longer-term away rotations
for pharmacy students who would like to gain more experience working in the Dominican Republic.

Benefits of Social Value

While De Camp reminds us that the benefits that STMM participants accrue in terms of medical and cultural education, can be of social value in that they contribute to the broader purpose of “global health equity through mutual caring,” (98) those benefits are elaborated upon in other sections of this chapter (“Education of Local Community and Team Members”). Therefore, in this section, my focus is on the benefits of social value that were highlighted during my interviews with community members, local doctors and local pastors.

The two benefits most mentioned by community members were provision of free pharmaceuticals and the engagement of the community in STMMs. A recurring theme in all of my interviews is that the operativos or STMMs are good “porque se dan medicamentos” or, “because they give medications” (Isabela). One woman even drew a correlation between the medications being “good” and being from the U.S., saying that she feels good after going to an operativo,

“porque recibo mis medicamentos, varias veces son bien buenos, los medicamentos vienen de allá afuera”

“because I get my medications. Sometimes they’re very good—the medications come from over there [from the U.S.]” (Lismeiri).

One informant mentioned that she sometimes she goes to an STMM because she finds it to be a convenient way to obtain simple medications like acetaminophen when
she is out of them (Salena). While this practice was socially disapproved of by other community members that I interviewed, it is still a common practice.

With respect to community engagement, many informants spoke positively of the encounters they had with the GSOP group, calling them “amigos” who “se preocupan por la comunidad” or who “care about the community” (Emeli; Antonio; Eva). Several people told me that they will come to an operativo even if they do not need to consult or obtain medication just to “compartir” or “share” with the GSOP participants (Rosa; Bernardo). This community engagement extends beyond interactions with the group of foreigners however. One informant synthesized it this way,

“Es más que una unión de dos grupos distintos, de dos nacionalidades distintas. Allí [donde hay operativo] puede ver también personas de la misma comunidad que quizás tengan tiempo que no se veían y se encuentran allí y quizás aunque son vecinos, no tienen tanto tiempo para compartir, pero allí en lo que es la espera, y el trato, pues, se juntan todos.”

“It’s more than two distinct groups or nationalities meeting and sharing. There [in the operativo], you can also see people from the same community who perhaps haven’t seen each other in a while meeting up. Maybe they’re even neighbors who don’t have much time to share with each other, but there, in the time they spend waiting and consulting with the doctor, everyone gets together” (Marelys).
A less directly cited, but nevertheless important, benefit was provision of healthcare consistent with the healthcare values of the community described in the introduction—respect, paying attention and spending time. When asked to compare STMMs to the usual place that they receive healthcare both in terms of the knowledge of their providers and how the experience made them feel, some interesting trends emerged. As explained in the introduction, respondents viewed the large regional hospital, Musa, very poorly. A lack of respect and lack of paying attention were two of the most often cited factors when this negative opinion was expressed. Pastor Diaz summarizes the general feeling about Musa, saying,

“La mayoría de las personas que se acuden al Musa, es por pura necesidad no porque dicen, ‘buen, allí lo mejor me atiende.’ Si tuvieron las condiciones de pagar en un centro privado, lo haría.”

“The majority of people who use the services at Musa do so out of pure necessity, not because they say to themselves, ‘That’s where I’ll get the best treatment.’ If they had the resources to pay for care in a private clinic, they would do it” (Alex Diaz).

This attitude toward Musa was strongly reflected in my interviews when I asked informants to compare their experiences at operativos conducted by the STMM to their experiences at Musa. Of the seven people who cited Musa as their place of regular healthcare, only one thought that her experience was better at Musa than at the operativo. She felt that the short-term nature of the operativo along with the fact that so many people attend and try to consult made the operativo more stressful than Musa. The six other informants, while agreeing that the training of the healthcare professionals at
Musa and in the *operativos* was equally good, said that the STMM team was more respectful, friendlier and “*más heavy,*” or more affectionate and loving (Emeli; Antonio). One informant rationalized this by suggesting that since STMM participants are intentionally taking time out of their everyday services, they make more of an effort to be friendly, while doctors at Musa are busy with their normal jobs and stop being friendly when things get stressful (Diana).

Among informants who regularly use the local UNAP, or public clinic, as their primary source of healthcare, opinions were more evenly split, some saying that their experiences in the UNAP and the *operativo* were equally good in terms of the services provided and the level of respect and paying attention of the providers. Others preferred the more in-depth contact they had with the doctors at the private clinic. One woman described the doctors at the clinic she attends as “*casi familia*” or “almost family” (Francisca). Informants who consistently used private clinics recognized the importance of the *operativos* for the poorer people in their community, but preferred to go to their usual clinic themselves rather than to the *operativo* citing convenience, more personal attention, and consistency with their doctor (Oria; Eva).

While the distribution of medication, the opportunity to *compartir* with the STMM team and other members of their community and the provision of care that aligns with their healthcare values are all benefits of STMMs identified by the local community, it is important to note that they do not indicate that the work done by STMMs is “desired and feasible” by the community itself—DeCamp’s major qualifier for what consists of a “benefit of social value” (98). For example, while informants generally agreed that the *operativos* hosted by the GSOP provide a service to the community, the majority did not see them as
distinct from political *operativos* or outreaches done by the local UNAP. No one indicated that they relied on *operativos* for their medical care, although two did suggest that they are highly beneficial for immigrants or other people without the Dominican documents needed to access the public system (Oria; Eva). These results are both encouraging and discouraging when it comes to evaluating the ethics of the STMM. On one hand, it is positive that the community does not appear to be dependent on STMMs for medical services, respecting and trusting the knowledge of local health professionals in their usual place of service as equal to that of the visiting healthcare providers. In the same vein, STMMs follow a pattern of *operativos* that is familiar to the community, allowing them to easily integrate STMMs into the healthcare they access. While this indicates that STMMs do not disrupt the usual provision of healthcare services, it is also concerning that they do not appear to have much of an impact on the community. In general, people seem to utilize them when they are available, but otherwise can procure healthcare elsewhere. This may indicate that the work that STMMs do in the community, while feasible, may not be desired or be meeting what the community would identify as a need. Moreover, duplicating care that already exists within the community violates one of Corbett and Fikkert’s main principles for avoiding dependency, “do not do for people what they can do for themselves” (175).

Additionally, while the sense of worth that community members gain from having a group of outsiders *preocuparse por la comunidad* may provide care in one aspect of health, the GSOP should examine whether or not they deem emotional and spiritual care to be a sufficient benefit to warrant the expense and preparation that goes into the trip. A non-medical mission trip would likely have a similar outcome and would avoid some of the
ethical challenges that are specific to the medical aspects of STMMs. Additionally, an event other than an STMM could undoubtedly provide an opportunity for the community to gather and share with each other, taking time out from the day-to-day worries to spend with their neighbors. If such an event were organized by the community, rather than by outsiders, it could also contribute to the community’s sense of empowerment.

**Education of Local Community and Team Members**

As a pharmacy school whose goal is to educate future pharmacists, education is a major component of STMMs for the GSOP. Often, students are participating in the STMM as a part of the APPE rotation, which requires them to take on leadership in preparations for the trip, train other students in basic triage skill during the trip and reflect critically on their learning experiences upon return (Brown and Ferrill “Part 3” 1113). As described previously in the section on collaborative partnership, education about the country in which the STMM works helps to facilitate GSOP participants’ learning about culturally competent care. This effort to understand the local community before intervening was noticed by one of my informants who, by virtue of working for the Gowers, has worked closely with GSOP teams for many years. She said,

“I've noticed the they before the arrive, they really have a knowledge about this place, about the culture....this makes you
realize that they really take the work they do very seriously, even though it’s short-term” (Marelys).

She also noted that the GSOP team takes the time to prepare *charlas* or presentations about various health issues that they then present to the community as a part of the *operativos*. As future pharmacists who will be counseling patients and providing health education, presentations to the community regarding different health issues is an important part of the practical experience for the GSOP students. At the same time, talks on STIs, proper nutrition, hypertension and diabetes provide a way for the STMM to impact people in the community who are not necessarily ill and seeking medical attention.

While education of students is a major goal for the GSOP, DeCamp cautions that, “educational benefits to the volunteers should not become an end in themselves” (98). Again, returning to the question of equality, it is important the community also benefit from education in a significant way. A step that the GSOP could take toward further community development is the education of local healthcare providers. Dominican physicians who regularly work with the STMMs hosted by the GSOP say that they enjoy working with the STMMs because they is able to share with another culture and learn things from them, both personally and professionally (Dra. Cruz. For Dra. Cruz, one of the highlights is getting to watch the pharmacy team prepare suspensions of drugs from pill form using special techniques. This happens informally as the physicians ask questions and interact with the team, but such education could be formalized. Perhaps a session in which the STMM exchanges knowledge with local health care providers could be implemented; students could learn from local doctors about diseases that are prevalent the region, the functioning of the local healthcare system or ask questions about a specific case
that was seen during the day, and GSOP participants could educate the local doctors on new drugs, compounding techniques or innovative options for pediatric dosing.

**Building the Capacity of Local Infrastructure**

While DeCamp specifically advocates for the building of capacity of local infrastructure, the positive and negative impact that STMMs have on local infrastructure need to be considered so that the negative, or what in research terms would be considered the risks, can be minimized and the positive, or the benefits, maximized. Several authors have raised concerns about the impact that importing healthcare providers for a short period of time has on local healthcare systems. Some worry that volunteers willing to provide free care could put local healthcare providers out of work (Montgomery 1993; Langowski and Iltis; Raines). Another concern expressed in a piece about the “best practices” in STMMs fears that patients in communities that receive STMMs will trust foreign doctors over local doctors, waiting for STMMs to return, often complicating disease or even losing their lives in the process (Soderling). According to interviews with physicians and community members, the GSOP avoids both of these pitfalls. When asked if they thought that there was any difference in the training or preparación of the foreign healthcare providers and local healthcare providers, everyone answered no. Moreover, the inclusion of local physicians as the diagnostic and prescribing experts of the STMMs, supports the work of local healthcare professionals and ensures that the GSOP pharmacists and students are not working beyond their skills set.

Local physicians and other healthcare professionals highlighted two other ways in which the GSOP contributes to the building the capacity of local infrastructure. In an
interview with Dra. Alvarez, a doctor in the public healthcare system who regularly collaborates with STMMS from the GSOP, she said of STMMS,

“Ayudan porque cuando hay operativos médicos se descentralizan un poco los sitios, los hospitales...porque la gente dicen, ‘hay operativo!’ bueno, no van a hospital cuando hay operativo...aunque no tenga nada, asi que estan dando las medicinas.”

“They help because when there are STMMS, they decentralize the load on other healthcare sites, on the hospitals...because people say ‘There’s an operativo!’ and they don’t go to the hospital if they can go to an STMM...even if they’re not sick they go to the STMMs, because they know that at STMMS they give medicine.”

Another way in which the GSOP team builds capacity of local infrastructure is through the donation of leftover medication and supplies. When I visited the local UNAP to conduct interviews with healthcare professionals, the nurse who runs the facility was very excited to show me the stock of gloves and anti-parasite medication that had been donated by an STMM from the GSOP a year before. As I learned in interviews with local doctors, while there is theoretically a system by which all public hospitals and clinics receive basic pharmaceuticals and supplies, the channels through which such supplies must be requested are bureaucratic and extremely inefficient (Genesis, Dra. Alvarez, Dra. Cruz). Thus, the donations from the STMMS fill in where the public healthcare system falls short.
While such fill-ins both in terms of personnel and medical supplies may be beneficial to the local community, it is important to consider the impact they have on the larger infrastructure of the Dominican Republic’s healthcare system. Perhaps by filing in the gaps with donated supplies the local clinics and hospitals have less incentive to hold the national healthcare system responsible for supplying them with what they need. Moreover, in relieving patient flow in the public system, STMMs may mask an overall shortage of local healthcare professionals. In other words, the well-intentioned and gladly received supplies and personnel may be propping up a broken system, disincentivizing larger, necessary changes.

A good first step to understanding these systems and the role that STMMs play in them would be for STMMs to visit local healthcare facilities and talk to healthcare providers about the positives and negatives of their facilities and systems. One pharmacy student who participated in a number of trips, including several that she organized made a visit to local healthcare facilities a part of the last trip she directed. She says, “I think a thorough understanding of the healthcare system in the country any medical mission goes to is imperative. Previously I never spent a lot of time getting to know the countries system but I realize that in order to figure out how we can best help and where we fit in the puzzle, we have to see the whole picture first” (Deanna Boone). This insight would be extremely valuable if applied to all of the GSOP STMMs, not just the ones that Deanna leads.

The GSOP misses the mark on one important aspect of building local infrastructure that DeCamp highlights, namely the “empowerment of the local community's voice” (99). While receptive to input from partner physicians, I have not seen them prioritize seeking input from the community. For example, when I asked local pastors who regularly
partner with STMMs about their experiences and their vision for the future of their community, the Diazes expressed a desire to have a more permanent partnership with the GSOP, perhaps establishing a clinic in their community that students could staff on a rotating basis. They said,

“Nos gustaría en algún momento tener un consultorio permanente para dar un servicio permanente. Muchas veces tenemos personas que sufren de asma, y casi se mueran antes llegar al Musa, pero sí hay en la iglesia servicios que se pueda utilizar...como un lugar de primer auxilio...Con la colaboración de enfermeras y médicos locales apoyo de equipo internacionales, extranjeros, que se pueden hacer un buen trabajo.”

“We would someday like to have a permanent clinic [in our church] that would provide permanent services. Many times, there are people who suffer from asthma and almost die before they can get to Musa [the local hospital], but if there were services in the church that people could use...like a place of first assistance...With the collaboration of local doctors and nurses and the support of foreign, international teams, we could do a good work”

While the Diazes shared this vision for their church and community with me, as far as I know, they have never had the opportunity to express that vision to the GSOP team. If the Diazes had, perhaps the GSOP could have empowered their voice and vision, helping to
sketch out plans for a longer-term partnership that would have a more permanent impact on the community.

A long-term partnership between STMMs and existing local healthcare services would greatly contribute the building of local infrastructure and would make the STMMs more effective in caring for patients and in their educational efforts. As the local UNAP’s purpose is largely preventative care, community education is a big part of their mission (Genesis). In partnering with the UNAP, the STMM could find out what major healthcare issues need to be addressed in the community. For instance, two years ago, after the outbreak of cholera in Haiti, there was great concern about the spread of the outbreak to the Dominican Republic. As such, many local health professionals, both in person, through radio ads and public awareness campaigns, were focusing on educating the community about ways to prevent transmission as well as about the signs and symptoms. The STMM from the GSOP arrived while all of this was taking place and was unprepared to answer questions that many of their patients had regarding cholera. Though they were able to piece together a community education presentation, a partnership with the local clinic and communication prior to the trip could have allowed them to arrive more prepared.

A collaborative partnership with the local community could also build infrastructure by providing practical training for local healthcare workers. For example, Dra. Cruz and Dra. Alvarez both highlighted a lack of patient chart organization as a major problem at the small hospital where they work. If the major challenge is that the charts are so disorganized that it is overwhelming, an STMM could provide the manpower needed to organize charts and get rid of duplicates. They could then collaborate with local healthcare
professionals to come up with a system of organization that would be useful and appropriate.

**Evaluation of Outcomes**

As stated at the beginning of this chapter, the goals for the STMMs conducted by the GSOP are rather broad and vague, making it challenging to conduct appropriate evaluation of outcomes. This vagueness and indefinability of success is reflected in the survey responses of GSOP participants. When asked whether they thought that the GSOP was effective in achieving their stated goals for the STMM, two out of the five respondents left this question blank and a third respondent simply said, “yes to a certain extent.” The other two respondents focused more on the spiritual impact of the trip, both for them personally and in the community. Documentation of educational impact such as logging hours with local healthcare providers or even keeping track of the number of people served would be valuable measures of outcomes. Nevertheless, as DeCamp points out, “the outcomes measured depend in part on the ethical justification for the trip in the first place” (99). For the GSOP, this means that the development of a clear set of goals would need to come before the meeting of those goals can be evaluated.

Interestingly, when it comes to goals for student participants, the GSOP is much better at evaluating outcomes, precisely because specific goals are outlined for students who are participating in the STMM for course credit. These six goals expect students to“(1) develop an understanding and appreciation of health care within another culture, (2) explain the daily working of a pharmacy setting in the context of a mission trip experience, (3) describe the pathophysiology, prognosis, clinical presentation and laboratory test findings of commonly encountered conditions in the hosting country, (4) deliver effective
pharmaceutical care to patients within a cross-cultural setting, as appropriate, (5) exhibit confidence with respect to communication with other healthcare professionals and patients, presentation skills, and literature evaluation, and (6) demonstrate servant-leadership skills” (Chahine and Nornoo 640). In addition to evaluating the students participating for course credit against an academic rubric, the GSOP has also conducted an exploratory study to analyze the experience of both APPE and non-APPE students through pre-and post-trip surveys. These surveys addressed issues of teamwork, patient care, and cross-cultural interactions (Brown et al. 1250). This evaluation of students demonstrates that the GSOP has systems in place with the capacity for evaluation. Applying these same systems to evaluating the “field” outcomes would allow the GSOP to track the ethicality of their work.

**Frequent Ethical Review**

While in an advisory column, Dr. Chahine, a faculty member at GSOP who has led STMMs to the Dominican Republic, admonishes other STMM planners to seek formal institutional approval prior to planning a trip, this approval centers more on “liability concerns, matters related to the distribution and accounting of funds, faculty workload issues and challenges with the scheduling of the usual campus-based student practice experiences” and not on an ethical review of the trip (638). A formalized IRB-like review process such as the one that DeCamp advocates has yet to be developed. Nevertheless, the GSOP certainly should strive to evaluate and question the ethics of its STMMs. As future healthcare professionals, their students will face ethical dilemmas in their work; the GSOP should take opportunities such as STMMs to help them develop the tools needed to think through the ethical implications of their interventions. When asked in a survey about
ethical concerns that the STMM raised, participants demonstrated that they are aware of and share some of the concerns addressed here and in other STMM literature. One faculty member said, “I wish we could provide something long-term to sustain the program” (Elias Chahine). Student participants also raised concerns regarding long-term follow-up (Matt Bamber), with one of them observing that “the biggest concern is providing a 30-day supply of prescription drug knowing the patient may not receive any follow-up care” (Deanna Boone). Deanna also pointed to a lack over ethical oversight of things like allergies or recourse for patients if an adverse reaction occurs. Clearly STMM participants are thinking about the ethical implications of their work, something that the GSOP could harness and use to more formally review the ethics of the STMMS it supports.
Chapter 4: Intersections of Religion and Health

While DeCamp’s model provides a helpful rubric for evaluating the ethics of the short-term medical missions (STMMs) undertaken by the Gregory School of Pharmacy (GSOP), the religious nature of the trips complicates the evaluation. For example, the evaluation of outcomes for goals like “providing spiritual care” and “sharing the love of God” are not as easily quantifiable as the number of prescriptions filled, patients attended to or hours logged in educating local healthcare providers. This does not mean that we should discount such goals or outcomes, merely that they need to be considered in the ethical evaluation.

How Do Religion and Health Intersect Globally?

The preamble to the constitution of the World Health Organization (WHO) defines health as “a dynamic state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (WHO 1948). While the definition has not been amended since 1948, in light of input from WHO officials in the Eastern Mediterranean, a 1983 resolution called for the inclusion of the “spiritual dimension of health” in WHO strategies (Khayat). Since then, the concept of a spiritual dimension of health has remained a part of the WHO’s strategies. In a 2008 publication entitled Building from Common Foundations: the World Health Organization and Faith-Based Organizations in Primary Healthcare, the WHO encourages member countries to include faith-based organizations (FBOs) in their overall healthcare plan, saying, “If health systems are to be strengthened, especially with a view to offering universal access to healthcare, many faith-based projects and assets could be used to meet this and other strategic aims of national health plans” (10). This encouragement of collaboration with FBOs is not merely pragmatic; rather, it
reflects the continued integration of the spiritual dimension of health into WHO strategies. Recognizing that many cultures value a more holistic, less materialistic perspective on health, the WHO encourages that a partnership between secular healthcare systems and FBOs, while complicating in terms of policy logistics and power structures,

“also opens the biomedical environment to a more holistic perspective on the nature of people in communities. Religious compassionate and communal values suggest a strong public service mentality. Religious ideas also challenge materialist approaches to health and well-being and offer more holistic perspectives, bringing a qualitative contribution through religious faith for individuals and communities” (WHO “Common Foundations” 14).

It is this qualitative contribution to health made by faith-based STMMs that I examine in the following section.

**Religion and Health in Barrio Madrid**

As Brendan Thornton explains in *The Cultural Politics of Evangelical Christianity in the Dominican Republic,*

“Evangelical Christianity is not a separate sphere, perceived as a foreign import, or regarded as an obscure marginal cult, rather it is an integral part of Dominican society and culture, dynamically engaged in the social drama, and as much a part of everyday life in the Republic (especially for barrio residents) as any other cultural, political or religious institution” (4).
In Barrio Madrid, evangelicalism and health are intertwined in a variety of ways, both on an individual and community level. Individually, my informants often highlighted the importance of prayer in relation to health. My interview questions did not ask about religious practices relating to health, so this was always a topic brought up by informants. The pastor of a local church mentioned that prayers for the health of her family, community and church are part of her everyday life (Guille). Another woman highlighted prayer as a way in which one can show respect or care for another person when they are ill (Esmeralda).

According to local missionary Dan Gower, there is a general belief amongst Dominicans that illness can have a spiritual component—both within evangelical circles and in the culture as a whole. Says Gower, “They do believe that there is a spiritual aspect to health, but not the point where it negates the role of doctors and scientific medicine” (Email Correspondence). Thus while the “faith healings” referenced in Whipfler’s characterization of Pentecostalism do occur (21), evangelicals also utilize biomedical care. In a very practical and concise summation of how she views religion and medicine intersecting, one woman said “Los médicos son puestos por Dios, entonces si uno se siente mal, uno ora, pero va al médico” or “Doctors are put in place by God, so if someone is sick, he should pray, but then he should go to the doctor” (Carmen). Overall, community member’s responses reflect a worldview in which biomedicine and religion are compatible, and even linked.

On a more communal level, religion and health intersect in the institution of the church. Many of the private clinics that community members highlighted as being places where they usually receive healthcare are run by local churches or religious
organizations. One community member said that she usually seeks treatment at a clinic run by a Catholic church in the main area of San Pedro (Marelys). Several informants also sought care at a clinic in a neighboring barrio run by the Episcopal church; it seeks to provide general health services to the poor including “rehabilitation, curative medicine, preventive medicine, mental health, community health, and health education” (Clinica Esperanza y Caridad). This health center also trains local “promotoras de salud” or “health promoters”—women who meet monthly to receive community health training, becoming equipped to participate in community health events such as vaccination campaigns and sexual health education (Carmen, Esmeralda). Two of the women I interviewed were promotoras de salud, and one of them invited me to attend a charla or a talk that she was giving about tuberculosis and STIs. I attended the meeting, which, in another intersection of religion and health, was held at the Daizes’ church.

One of the healthcare values that Gretchen Schumacher’s transcultural nursing study *Culture Care Meanings, Beliefs and Practices in Rural Dominican Republic* highlighted was the importance of the family as a social network, especially in relation to health. My interviews with community members corroborated Schumacher’s findings, as all but one person agreed that family presence aids in recovery from illness, and that not having family present negatively affects health and well-being. One man put in this way,

“*yo creo que la salud, la curación de una persona no solo se va a los medicamentos, que no en el efecto también, en la compañía,*

*porque si...le están dando medicina...pero se siente solo, se deprime como que no puede responder.”*
“I think that the health and recovery of a person isn’t just through medicine, rather, it’s also in the impression, in the company that a person is in. A person can be given medication, but if they feel alone, they get depressed and they don’t respond” (Alex Diaz).

Family as a part of healthcare extends beyond emotional support, however, as many of my informants cited family members as people they often seek health advice from. Whether it be a cousin who is a doctor, a grandson who is a pharmacist or a grandmother who knows how to prepare teas that will help with a cough, family is an important part of healthcare in Barrio Madrid.

With family being such a major social network in the Dominican Republic and residents in Barrio Madrid agreeing that not having family as part of the recovery process negatively affects outcomes, it would seem that those who do not have family nearby are at a disadvantage. Here, the church is involved in health in a different capacity. One woman shares her experience:

“Yo tuve una operacion allí y me hizo falta a mi familia. Ellos no llegaron, y no venía attenderme allí pero gracias a Dios la iglesia me ayudaba mucho los hermanos.”

“I had an operation over there [at Musa] and I really missed my family. They couldn’t come be with me, but thanks be to God, the church and my brothers and sisters in the church helped me very much” (Katerina).
The idea of a “church family” or the church as a group of people, rather than a building or institution takes this intersection of health and religion within the church even further. Not only are churches entities that fund clinics or buildings where community health talks can be given, they are a social structure that provides support to community members. In his book *Reason to Believe: Cultural Agency in Latin American Evangelicalism*, David Smilde argues, “Evangelicalism is a means by which poor Latin Americans address the challenges they are confronted with” (4). Moreover, the church, in hosting events such as STMMs becomes a place of unity, a place where two cultures can come together and share. One woman described STMMs as a chance for the community to forget their daily struggles for a few days and enjoy sharing with friends new and old:

“La iglesia como tal es el punto que une esos dos grupos y hace posible esa unión. Y muchas veces se olvidan de que son culturas distintas, de que son idiomas diferentes, y es bonito. Sobre todo, es bueno para comunidades como esa. Que el mismo hecho de la miseria, y la carencias que tiene es como una semana de alegría donde las actividades ordinarias se paren y no importa pasar dos o tres días allí compartiendo con esa gente. Entonces es bonito...bien bonito”

“The church itself, is the point at which these two groups [the STMM group and the local community] meet; it’s what makes the union between them possible. Many times they forget that they are from different cultures, that they speak different languages, and it's beautiful. Above all, it's good for a
community like this. In light of the misery and the cares that they have, it’s a week of happiness when ordinary activities stop, and no one minds spending two or three days there [at the church] sharing with these people. So it’s a beautiful thing...really beautiful” (Marelys).

While my interview questions did not intentionally probe the intersections of religion and health in Barrio Madrid, it is interesting to note that the mixing of religion and health is an everyday occurrence for community members—something that happens as they seek healthcare, become educated about community health concerns or show care for someone who is ill.

**Ethical Considerations of Faith-Based STMMs**

While the WHO has recently begun promoting collaboration between faith based organizations and local governments in an attempt to pool resources and work together for better health outcomes, the short-term nature of STMMs complicates this attempt at partnership. As discussed in Chapter 2, short-term endeavors often enter a community saying, “this is what you need” rather than partnering with the community to assess assets and needs in a collaborative way. When a group enters a community with not only medical knowledge, but also spiritual knowledge, the playing field may become even more uneven, making the ideal of a collaborative partnership even more challenging to achieve. As Smilde explains, “Membership in a church means that other hermanos both feel obliged to assist an individual and have more confidence in his trustworthiness” (79). This implicit trust must be acknowledged and carefully navigated by the STMM, with care being taken not to abuse the privileges they have as “in” members of the faith community. Moreover,
while the interactions of the GSOP STMMs with the religious practices of the community are largely observatory, it is important in their efforts to “share the love of God” and “evangelize” team members do not perpetuate a sense of dependency or give in to a colonial affect that presents American iterations of faith expression as superior to local embodiments of faith.

The WHO cites G. Clarke’s work *Faith Matters: Development and the Complex World of Faith-Based Organizations* in the provision of a four-part gradation that describes how faith influences the way in which FBOs interact with receivers. These four categories are Passive\(^3\), Active\(^4\), Persuasive\(^5\), and Exclusive\(^6\). While it can be assumed that an interaction that falls into the exclusive category and manifests as “militant or violent” is ethically undesirable, the WHO does not go so far as to recommend what level of faith influence is acceptable. However, in providing a gradation scale, the WHO provides a tool by which faith-based STMMs can self-evaluate their faith influences, modifying them if they do not reflect the goals of the trip. In its STMMs, the GSOP falls somewhere between active and persuasive faith interactions. While their stated goals of “evangelism” fall into the “persuasive” definition along the lines of “aiming to bring new converts to the faith,” that aspect of the STMM is generally left up to the local church members, and mostly consists of

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\(^3\) Passive: “Faith is subsidiary to broader humanitarian principles as a motivation for the action and in mobilizing staff and supporters. Faith plays a secondary role in identifying, helping or working with beneficiaries and partners.”
\(^4\) Active: “Faith provides an important and explicit motivation for action and in mobilizing staff and supporters. It plays a direct role in identifying, helping or working with beneficiaries and partners, although there is no discrimination against nonbelievers and the organization supports multifaith cooperation.”
\(^5\) Persuasive: “Faith provides an important and explicit motivation for action and in mobilizing staff and supporters. It plays a significant role in identifying, helping or working with beneficiaries and partners and provides the dominant basis for engagement. It also aims to bring new converts to the faith or to advance the faith at the expense of others.”
\(^6\) Exclusive: “Faith provides the principal or overriding motivation for action and in mobilizing staff and supporters. It provides the principal or sole consideration in identifying beneficiaries. Social and political engagement is rooted in the faith and is often militant or violent and directed against one or more rival faiths.”
offering to pray with patients or participating in worship services. In practice, while faith inspires their work and motivates their partnerships, attempts to bring converts to the faith or advancing faith at the expense of others rarely, if ever occurs. The goal of “sharing or showing the love of God” through their interactions with others and through the services they provide appears to be paramount.

While goals that include “providing spiritual care” and “supporting the work of the local church” may seem like their outcomes would be difficult to measure, it is nevertheless an important endeavor to assess all of the outcomes of an STMM. Metrics such as church attendance, feeling of spiritual well-being amongst recipients and increased familiarity with the programs offered by the church would all be measurable outcomes. It is important to note that just as the long-term effects of the 30-day supply of pharmaceuticals and annual interventions by an STMM are questionable, so are the long-term effects of spiritual care. While there have not been any studies that evaluated the effects of spiritual care in the receiving community, Bajkiewicz cites a study that evaluated the long-term spiritual effects of a short-term mission on the participants. The study, done over the course of a year with 116 participants found that “participants’ prayer, Bible study, faith community involvement and evangelism decreased over the course the year either pre-experience levels or, in some cases, to below pre-mission trip levels” (Friesen 2005 qtd. in Bajkiewicz). Short-term “successes” even in spiritual matters do not always correlate to long-term outcomes.

Since faith-based STMMs interact not only with the healthcare systems of the Dominican Republic, but also with the religious institutions it is equally important that participants maintain an attitude of learning and tolerance in religious interactions. In a
dissertation on non-medical short-term missions, Jeffrey Raines found that “negative stories of imposition...dealt with matters of theology and polity. Receivers expressed frustration that their embodiments of Christianity were challenged by short-term team members” (47).

In my observations of the GSOP participants, they have not attempted to confront any theological or methodological differences between the Dominican expression of faith and their own. Rather, they see attendance at a local church service as a chance to learn about a the ways in which a different culture embodies Christianity, often staying after the service to talk with church members or continue worshiping through song and dance. One team member described her experience as follows:

“My first experience in a Dominican church was overwhelming! I think mostly because I have limited Spanish language skills. Dominicans are very passionate and the messages definitely convey that. My absolute favorite part is the joy. Dancing around with the entire congregation after Pastor Alex or Mercedes give the message goes down in my book as the ultimate experience I’ve had with my Dominican friends. Dance knows no language. In those moments, we are just worshipping and thankful for each other. It’s pretty awesome” (Deanna Boone, Personal Email).

Such an attitude of openness and sharing is encouraging to see as part of religious interactions. Nevertheless, the GSOP team should be aware of the fact that such
interactions also have ethical implications, and should have guidelines in place for interacting appropriately and ethically.

In *Building from Common Foundations*, the WHO highlights compassion and decency or respect of person’s dignity as a universal attribute of faith that allows diversity of organizations to work together to achieve better health for a community (11-12). While the importance of church institutions both in the provision of healthcare and as social structures that allow community members to have a system of support indicate that faith-based STMMs may have some advantage in the community as well as meet a desired outcome, the religious dimensions of STMMs do complicate the ethical considerations. It is critical to note that being inspired by a religious call to compassion for the sick neither negates nor elevates the work done by religious healthcare professionals. Therefore, it is important that in interactions with the local community, STMMs avoid any effect of colonialism, ensuring that they are not undermining local structures of either healthcare or religion. Additionally, it is imperative that the STMMs maintain openness, not discriminating against patients who do not share their religious beliefs.
Chapter 5: Empowerment and Intercultural Competence

As we saw in Chapter 3, the largest category of ethical principles in short-term medical missions (STMMs) is empowerment. With that in mind, it is important to consider that perhaps the ultimate goal of STMMs should not be provision of services, a religious interaction, or even the dispensing and receiving of knowledge. Rather, the focus should be on empowering the local community to identify and address its own health needs. Empowerment can come through services, religion and the exchange of knowledge, but the end goal is not that the community becomes a receptacle of these things, but rather an empowered agent of its own future. In this chapter I will begin by showing how intercultural competence is paramount in any relationship that seeks to be ethical and empowering. I will then discuss ways in which knowledge and religion as part of the model for interactions between STMMs and the community can be tools for empowerment. Finally, using several different models, I will develop a working definition of empowerment, proposing an ideal model for ethical partnerships between STMMs and the communities in which they work.

Intercultural Competence

The introduction to the *SAGE Handbook of Intercultural Competence* cautions, “Intercultural experience alone is not enough; it is not enough to send someone into another culture for study or work and expect him or her to return interculturally competent...Building authentic relationships, however is key in this cultural learning process—through observing, listening and asking those who are from different backgrounds to teach, to share, to enter into dialogue together about relevant needs and issues” (Deardorff xiii). The building of these “authentic relationships” in the context of
STMM and community interactions requires humility and a recognition of privilege on the part of STMMs and also requires the empowerment of the local community in order that its members may participate as equals in the relationship.

Empowerment is extremely important in the patient-healthcare provider relationship, as the healthcare provider’s status as an expert creates a hierarchical power dynamic in which the patient is inferior to the provider, even when the patient is discussing his or her own health. This power dynamic can be even more skewed when the provider and patient are from different cultures, as biomedical views may conflict with local beliefs about the etiology of disease. A way to mitigate this hierarchical dynamic is through the deconstruction of ethnocentrism, as ethnocentrism can negatively affect the quality of care that patients receive. In Developing Skills for Interculturally Competent Care, Anad and Lahiri argue, “If a provider is ethnocentric, his or her interactions, diagnosis and treatment will be skewed by his or her biases. Intercultural competence is central to equalizing power dynamics in medicine that often lead to those with less power (such as those in a cultural, ethnic, linguistic or economic minority) receiving a lower quality of care” (390). One way in which ethnocentrism can be deconstructed is in the privileging of local knowledge. This means understanding and respecting local healthcare values, such as the ones studied in Schumacher’s research as well as my own. Anand and Lahiri propose a variety of ways for dealing with conflicts between the beliefs of the patient and the provider. Underscoring all of them “is the importance of the provider listening to the patient’s explanation of the cause of illness without judgment” (398). This means respecting healthcare values that may seem odd or “backward” in the context of biomedicine.
One such value that may cause U.S. educated healthcare professionals pause is the Dominican prioritization of family in healthcare. As summarized in the introduction, my research corroborated Schumacher’s findings that “family presence is essential for meaningful care experiences and care practices” (97). While that may not seem like an odd statement, it provides the backdrop for a cultural practice that American individualism would find odd: often, especially in the case of a serious illness such as cancer, a Dominican healthcare provider will inform family members of the diagnosis, but will not tell the patient (Dra. Alvarez). This stems largely from the Dominican belief that people can and do die of shock, sadness and nerves. That is, that if a patient is given a terminal diagnosis, he or she could die of shock or could lose the will to live. Therefore, the family of the patient is entrusted with the diagnosis so that they can communicate it to the patient as they see fit. Not all local doctors follow this practice; Dra. Cruz feels that it is important that patients understand their diagnosis so that they can make their own decisions about their care. Nevertheless, she acknowledges that certain illnesses like HIV or cancer have to be handled carefully and she deals with these diseases by providing her patients with psychological counseling along with the diagnosis. While the cultural norm might be that doctors communicate with family members and not the patient, several of my informants refuted this, explaining that they feel respected when a healthcare provider takes the time to explain their diagnosis to them. These differences in preference for dealing with serious diseases highlight the need for STMMs to form relationships with the local community, acknowledging the underlying cultural practices, but also attempting to understand the individual patient’s preferences.
Relationships and “developing skills to learn about cultural and personal beliefs in a respectful fashion” (Lahiri and Anad 388) come through time spent interacting with the local community. This time to build relationships can be hard to find in the busyness of the daily clinics run by STMMs. Therefore, a model for short-term missions such as the one proposed by Glen Schwartz, in which teams are small enough that they can stay with local host families would be beneficial in promoting relationships and encouraging the STMM team members to approach their trip with humility, gratitude, and the attitude of a learner (“Maximizing the Benefits”). Corbett and Fikkert also advocate this attitude of learning and advise, “Design the trip to be about ‘being’ and ‘learning’ as much as about ‘doing.’ Stay in community members’ homes and create time to talk and interact with them” (175).

Beyond simply engaging more with the local culture, I believe that such an approach could also help empower the local community. Economically, local families could earn extra money by hosting STMM participants for a small fee that would cover housing, food and other expenses. Moreover, in acting as the hosts to STMM participants, the local community is put in a position of power as it is made clear that the STMM participants are guests in their community, present to learn and listen.

**Knowledge**

As Nina Witjes has recently noted in her critique of the World Bank’s Development Gateway, knowledge has been intricately involved in discussions of development since the 1950s. The World Bank has viewed knowledge as a solution to poverty that can “save lives and create development” (Witjes, 30). Witjes argues that this implies that “it [knowledge] is available (mainly in the global North) and can be transferred (mainly to the global South)” (Witjes, 30). The World Development Report supports this implication, saying,
“poor countries—and poor people—differ from rich ones not only because they have less capital but because they have less knowledge” (qtd. in Witjes 30). Unfortunately, such an emphasis on the poor’s lack of knowledge, especially in the publication of an organization as influential as the World Bank, is extremely disempowering and exacerbates inequalities between the Global North and the Global South.

Even as I and other scholars interested in STMMs have discussed the importance of education as a long-term goal for ethically competent STMMs, we have largely ignored what education or knowledge means. While not explicitly stated, we have assumed that healthcare professionals, with their formal training, have knowledge to impart to the community they are serving—via charlas, individual consults and prescription counseling. In return, we expect the community to largely provide information—about local health systems, prevalent diseases or cultural customs. Witjes proposes a more productive and nuanced view of knowledge that conceives of it as “imperfect, socially constructed and diverse, which is situated and cannot be detached from its cultural, political and economic context” (32). This more nuanced view of knowledge, separating it from professional training, privileges local knowledge over foreign knowledge, as relevant in the cultural context in which it is produced. When we do the converse, privileging knowledge from the Global North as more relevant, “it is not likely to fulfill the needs of people in developing countries, especially when local and indigenous knowledge is excluded” (Witjes, 32).

I propose an empowering view of information and knowledge is one that views them a continuum of sorts. Information becomes knowledge over time, through practice, modeling and following, eventually becoming what one might call wisdom—a knowledge
that is possessed without the awareness of its possession, an inherent knowledge[^7]. It is that sort of knowledge that STMMs must seek to uncover in the empowerment of the communities in which they work. Moreover, if STMMs want the information that they bring with them to feed into the empowerment of the community, time is a crucial factor. While the community should be the one empowered to decide whether or not they want to spend the time investing in the practices that lead from information to knowledge, if the STMM does not commit to long-term relationships, such an empowerment can never occur.

**Religion**

In a meta-synthesis of several studies that dealt with the empowerment of Hispanic/Latinos in regards to health, Amendola found that empowerment came through the sharing of responsibility, and through the projection of a cohesive identity as a minority, providing a sense of self-confidence to the community members (86-88). These findings cohere with Thornton’s argument that in the Dominican Republic, this sort of empowerment is often enacted, especially by ethnic minorities, through involvement in the Evangelical, specifically, the Pentecostal church (Thornton, 223-227). He says, “Because one chooses to join the church and the respect one receives is entirely dependent on acts of the individual, Pentecostal faith represents a powerful moment of agency and self-determination” (224).

As discussed in Chapter 4, faith-based STMMs are in a unique position as they interact with the community at the intersection of health and religion. By sharing responsibility for hosting an *operativo* with the local Evangelical church, the STMMs affirm

[^7]: Thanks to Dean Laurie Patton for providing this insight during a conversation about these topics.
church members’ identities and the empowerment that church members find in Pentecostalism. STMMs could enact this empowerment on a greater level in the community if they were to develop a truly collaborative focus, in which communities are given the tools to define and find solutions to their local health problems.

In an even more radical approach to religion, empowerment and social change, Eboo Patel advocates for interfaith collaboration. While he acknowledges that historically religion has often been a source of oppression and exclusion, he points to faith-based activism as a hope for the future. Rather than seeing faith as divisive, violent, conquering or conflicting, he encourages universities to “actively and positively engage faith identity” (Patel). More than just an academically rich exercise, “how people from different faith backgrounds get along and what they do together is a crucial question” (Patel).

As a university, the GSOP identifies with the Christian faith. Nevertheless, they are training pharmacists who will practice in a world filled with people who have other beliefs. I challenge the GSOP to explore that “crucial question” of interfaith collaboration through STMMs, broadening its goal of bringing health to include partners who do not share their faith. Within the Dominican Republic, a small way to move toward interfaith work would be to encourage Catholic and Protestant Christians to reconcile their differences, recognize their common faith and work together to solve the health problems of their community. Bringing in people from differing faith perspectives could enrich the STMM/community interaction, facilitating greater intercultural competence and more innovative solutions to healthcare issues.

Two models of STMMs
When I first began my research in the Dominican Republic, I had a view of short-term medical missions (STTM) that looked something like the diagram below:

True to the stated goals of the Gregory School of Pharmacy (GSOP), STMMs brought services—healthcare, medications, medical knowledge and education—as well as evangelism, or as some called it “spiritual care.” While I rightly surmised that the ethics of the interactions between the STMMs and the community were not ethically neutral, this model was inherently flawed, and the addition of ethics to the arrows did not resolve it. In this model, the community is always the recipient of whatever the STMMs choose to bring; it is not an agent in its own future. This view can and has led to dependency in Barrio Madrid.

When empowerment is taken as an ethical value, as it is in DeCamp’s model as well as mine, this view of STMMs can be expanded into one in which the STMM provides services, knowledge and religion in a way that leads to the community becoming empowered. This view, pictured below, uses dashed arrows to recognize that those three
elements come not only from STMMs, but are also inherent in the community itself.

Intercultural competence (ICC) is present, mediating all of the interactions.

While this view is improved, in that its focus is the production of an empowered community, the community is still mainly viewed as a recipient and not as an agent.

Moreover, the very concept of empowerment is ethically fraught. What happens if a community wants to remain dependent on outside assistance? Should teams come in and impose our outside knowledge that dependency is bad and “empower” them against their
will? With this in mind, I seek to develop a working definition that in the context of STMMs promotes ethical interactions.

Drawing from the Latin American Catholic tradition of Liberation Theology, I envision agency as self-determinism, or as Phillip Berryman puts it, “the poor should not simply be integrated into existing structures, which can be oppressive, but should become autores de su propio progreso, subjects of their own development” (Berryman 28). This idea of self-determinism strongly relates to the idea of empowerment as the ability to reject the services offered. That is, the community must have the ability to determine whether or not they wish to participate in the “existing structures” offered by STMMs or if they see another route as more favorable to their development. Such questions could be addressed in a collaborative discussion between community and STMM leaders, while still affording community members the agency to attend the clinics run by STMMs or not.

**Empowerment as the ability to say “No.”**

As DeCamp’s model affirms, collaborative partnerships can only be undertaken between equals and must avoid imposing outside ideas on a community or creating a sense of dependency (“Review” 98). In order for the community to be empowered to act as equals, with the power to decline assistance when it does not align with their vision for the future, the issue of pre-existing dependency must be addressed. As the local missionary family, the Gowers, explained, the people in Barrio Madrid, “tend to have a high view of ‘gringolandia’ [the U.S.], and a high view of anything free, so to them, STMMs are a good thing” (Dan Gower). This idea, combined with the correlation that “with the Americans come free things” can be damaging as the community becomes accustomed to outsiders doing for them what they could have done for themselves. It also contributes to a lack of
ownership among the local community. For instance, Pastor Diaz’s church receives several short-term mission teams per year. In light of the many children present in Barrio Madrid, one team undertook the building of a playground in the dirt yard next to the church. For a while, the children of the community enjoyed the playground, however after a couple of years it fell into disrepair. Pieces of wood began to rot, the ladder to the slide was missing rungs, and no mission team came to repair them, so the playground sits, unused and, in fact, dangerous because the community did not see it as their responsibility and instead viewed it as belonging to the foreign short-term mission team.

Pastor Diaz has been working to assert his voice and vision for the community and teach his church to do for itself rather than remaining dependent on outside intervention. Two years ago, the church decided that it needed a new floor, as the old one was made of cracked, uneven concrete and was set so low that every time it rained, rivers of water rushed through the church. A well-meaning short-term mission team offered to pay for the new floor—it was only a few hundred dollars and could be completed in a matter of weeks. Pastor Diaz graciously declined their offer, insisting that the congregation could and would raise the money to pour a new concrete floor. It took over a year for the small church to raise enough funds, but they did it by themselves. When I returned this past summer, the church members’ first comment after greeting me was usually, “Have you seen our new floor?” Ideally, this sense of ownership will carry forward, causing them to want to maintain the condition of the floor. As this story shows, breaking the cycle of dependency is difficult; it requires turning down the easier and faster way of accomplishing goals in favor of a way that empowers the local community to realize and utilize the assets they have.
While Pastor Diaz is attempting to empower his community by saying “no” to the offer of outside intervention, STMMs must try to look at things from his perspective and realize that he is in an exhausting position. His community has needs, and short-term mission teams—medical and otherwise—are offering to meet those needs. In light of this, continuously refusing outside assistance is likely burdensome. STMMs should make this process easier for leaders like Pastor Diaz by utilizing models of partnership and asset-based development that have been discussed in Chapter 3.

**A new model for STMMs**

An ethical and empowering model of STMMs requires transformation both of the STMMs and the community. Firstly, STMMs must experience a change in attitude, exchanging their position as experts for the position of learners. This would entail the embracing of self-reflection, efforts toward intercultural competence and an attitude of deference to the community. There must also be a transformation within the community in order for it to become self-determining. Leaders like Pastor Diaz are needed to call the community to action in determining its own future. These transformations could be achieved through the above model that produces an empowered community, but also through other strategies. For instance, the STMMs could meet with community leaders and say, “we will come, but we will only come if you tell us what you want from us and how we can partner with you toward greater global health equity.”

With those transformations in place, the relationship between a self-determining community and STMMs could look something like the diagram below.
This diagram depicts a self-determining community that is giving the experience of STMMs to an STMM team while receiving healthcare services from that STMM. This exchange is mutual and is mediated by intercultural competence (ICC), however the community is purposefully on top, showing that they are agents in their own healthcare decisions and that they have the ultimate say in the interactions. Knowledge and religion are no longer possessed by either of the groups in this model, but rather are shared back and forth as the community and STMMs listen to and learn from each other.

**The Ethics of the Arrows**

My goal in this thesis was not to provide an ethical model that works for all STMMs in all places, for all of time. Rather, I have interrogated existing models, testing their limits and applicability, adding in components such as religion that complicate as well as enrich STMMs. In the end, this thesis demonstrates that STMMs require constant nuanced ethical thought. The very idea that I have espoused in this chapter—namely that empowerment is
“good”—makes an ethical judgment. Any time such a judgment is made, participants in STMMs as well as academic critiques need to be aware that there are ethical implications. Indeed, any interaction between STMMs and the community—every arrow in my above diagrams—has ethical implications of which all parties need to be cognizant.

Moreover, the work that I do in this thesis is incomplete and leaves some ethical questions uninterrogated, possibilities for future scholars of STMMs to explore. One of those areas for future research is in the ways in which the presence of an interpreter further complicates the STMM-community interaction. While I did not conduct research in the particular community, there is a nearby community in which the majority of older adults are first-generation Haitians, necessitating two translators to facilitate interactions. Another point to keep in mind is that the spiritual health beliefs in that community may be different than in the community where I conducted my research. A study of that community’s interactions with STMMs, especially in linguistic terms would be extremely rich academically.
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Initial interview questions/themes for community members

1. ¿Cual es tu reacción a las siguientes declaraciones?
   a. Cuando su familia este presente, ¿recupera de una enfermedad más rápido?
   b. Cuando esta enfermo y su familia no este presente, ¿afecta a su salud y bienestar en una manera negativa?
   c. El respeto y la cortesía ¿son unas características esencial en proveer y demostrar cuidado para otros?
      i. ¿Cómo uno demuestra cuidado para otros a través del respeto?
   d. ¿Cree que cuando un cuidador le está prestando atención, el/ella está cuidando sus necesidades emocionales y físicas?
   e. ¿Cómo se siente cuando un cuidador no le está prestando atención?
   f. ¿Es beneficioso para usted ir a una clínica o hospital publica?
      i. ¿Cómo es beneficioso?
   g. ¿Es beneficioso para usted ir a una clínica o hospital privada?
      i. ¿Cómo es beneficioso?

2. Cuando necesitas consejo medico ¿con quien de su comunidad consultas?
   a. Los profesionales de la salud (doctores, enfermeras, etc.) ¿los ve como parte de su comunidad?

3. ¿Usualmente, donde procuras cuidado medico?
   a. Para ti?
   b. Para sus hijos?
      c. Háblame un poco sobre este lugar, sus servicios, lo bueno y lo malo.

4. ¿Qué significa que su cuidador de salud te respete? Acciones, palabras, ¿como se siente?

5. Alguna vez ¿ha conseguido cuidado medico de un equipo misionero?
   a. Si no, ¿alguien en su familia?
   b. Si sí, ¿cuántas veces?
      c. Háblame un poco de su experiencia, los servicios que consiguió, lo bueno y lo malo.

6. Alguna vez has conseguido cuidado medico de (fuente normal del cuidado) y de un equipo misionero al mismo tiempo?

7. ¿Cómo compara el cuidado que recibe del equipo misionero y el cuidado donde usualmente procuras cuidado medico? ¿Cómo son semejantes, cómo son distintos?

8. ¿cuál es su opinión del cuidado que recibió en el lugar normal y del equipo misionero en términos de:
   a. La información que sabe los profesionales de la salud? (su preparación)
   b. La personalidades de los profesionales de la salud? (su forma de ser)
   c. Respeto y cortesía recibido de los profesionales de la salud? (como le tratan)
   d. La participación de la familia en su cuidado? (permite que su familia sea presente)

9. ¿Como te sientes después de recibir cuidado en su lugar normal?
   a. ¿Cuáles son sus emociones?

10. ¿Cómo te sientes después de recibir cuidado de un equipo misionero?
    a. ¿Cuáles son sus emociones?

11. ¿Hay algo mas que quieres decir sobre el lugar donde usualmente recibes cuidado o su experiencia con un equipo misionero? ¿Algo que quiere contar
Appendix B

General questions about the doctor’s work:
1. ¿Por cuánto tiempo ha trabajado aquí?
   a. ¿También trabaja en otros lugares o en clínicas privadas?
      i. ¿Es común que los médicos trabajen en diferentes lugares?
2. ¿Cuándo empezaron la programa de tener centros de atención primaria en los barrios?
   a. ¿Cuándo se fundaron este centro? (Parte del programa de Juan XXIII?)
3. ¿Qué tipo de servicios ofrecen aquí?
   a. ¿Cuántos doctores hay?
4. ¿Este lugar es público o privado?
   a. ¿Los pacientes tienen que pagar para consultar?
   b. ¿Tienen que pagar por análisis, medicamentos etc.?
5. ¿Usualmente tienen aquí los medicamentos que los pacientes necesiten?
   a. Si no los tienen, ¿qué hace?
6. ¿Qué pasa cuando un paciente necesita los servicios de una especialista? ¿Tiene una sistema de referencias?

Opinion questions:
1. ¿Cuál es su opinión acerca de las siguientes declaraciones?
   a. La presencia de la familia es importante para la recuperación de un paciente
   b. Cuando la familia de un paciente no este presente durante una enfermedad, ¿afecta la salud y bienestar del paciente en una manera negativa?
   c. Respeto es una característica esencial en proveer y demostrar cuidado para otros
2. Como un(a) doctor(a), ¿como presta atención a sus pacientes?
   a. ¿Cree que es importante conectarse con sus pacientes emocionalmente?
   b. ¿Qué significa respetar sus pacientes?
3. ¿Cree que sus pacientes pueden entender las enfermedades que tienen?
   a. ¿Cree que es importante explicar a su paciente lo que tienen?
   b. ¿Cree que es importante explicar a su paciente los razones por su tratamiento—porque ellos necesitan hacer un análisis, o tomar un medicamento?
4. ¿Ha trabajado en operativos médicos?
   a. Háblame un poco sobre su experiencia realizando un operativo médico
      i. ¿Quién lo organizó?
      ii. ¿Cómo participó usted?
      iii. ¿Cuántas veces ha participado?
5. Alguna vez ¿ha trabajado con un grupo de extranjeros (un equipo misionero) para hacer un operativo médico?
   a. Si sí, háblame un poco sobre su experiencia
      i. ¿Quién lo organizó?
      ii. ¿Cómo participó usted?
      iii. ¿Cuántas veces ha participado?
   b. Si no, ¿sabe que grupos vienen para hacer operativos médicos cerca de aquí?
      i. ¿Cuál es su opinión acerca de estos grupos?
6. En su opinión, ¿Cuál es el propósito de los operativos médicos?
   a. Los que hacen usted misma
b. Los que hacen los grupos misioneros
7. Los operativos médicos, ¿son beneficioso?
   a. ¿Cuáles son aspectos positivos y negativos de los operativos médicos?
      i. De los que hacen usted misma
      ii. De los que hacen los grupos misioneros
8. ¿Cómo compara el cuidado médico que provee en operativos médicos y lo que provee en el lugar donde usted trabaja?
9. ¿Usted piensa que los equipos médicos que vienen desde afuera entienden las necesidades de la comunidades en que trabajan?
   a. ¿Por qué sí? O ¿por qué no?
   b. Es importante entender la comunidad donde trabajan?
10. ¿Hay algo más que quiere decir sobre su experiencia trabajando en operativos médicos?
Questions for STMM participants

1) When did PBA start sending short-term medical missions to the Dominican Republic?
   a) Before the DR, where?
2) Where else have they gone?
3) How do they choose where to go? Who is involved in that decision? (students, professors, administrators?)
4) What sort of training takes place before the short-term medical mission, especially in terms of cultural awareness, language, etc.?
5) Why did you choose to participate in a short-term medical mission?
   a) What were your personal goals for the trip?
6) How did the trip impact you personally?
   a) Professionally?
7) What is/are the stated goals of the trip for students?
8) What is/are the stated goals of the trip for the communities where you serve?
9) Do you feel like the stated goals are met?
   a) If so, how? If not, why not?
10) Did the trip raise any concerns for you?
    a) About healthcare access?
    b) About the effectiveness of trips such as the one you participated in?
    c) Ethical concerns?
    d) Other concerns?